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DEFENSE HEALTH BOARD

DOD TASK FORCE ON THE PREVENTION OF SUICIDE BY MEMBERS OF THE ARMED FORCES

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P R O C E E D I N G S

(9:03 a.m.)

MAJOR GENERAL VOLPE: I'd like to welcome everyone to the meeting of the DOD Task Force On Prevention of Suicide by Members of the Armed Forces which is a subcommittee of the Defense Health Board. We have several important topics on today's agenda and we'd like to begin those here shortly, so I'm going to turn it over to Colonel McPherson. Can you please call the meeting to order?

COLONEL McPHERSON: Thank you, General Volpe. As the designated federal officer for the Defense Health Board, a Federal Advisory Committee and a continuing independent scientific advisory body to the Secretary of Defense via the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Military Departments, I hereby call this meeting of the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces, a subcommittee of the Defense Health Board, to order.

MAJOR GENERAL VOLPE: Now carrying on the tradition of this task force and all boards that are done with the Defense Health Board, I'd like us all to stand for a minute and honor those men and women who are serving and who have served our nation.

(Moment of silence.)

MAJOR GENERAL VOLPE: Thank you. Please take a seat. Since this is an open session, before we begin I'd like to go around the table and have each of the members of the task force and distinguished guests introduce themselves at this time. If we could start, David, down at your end and if you could just introduce yourself shortly.

DR. LITTS: I'm David Litts. I'm a retired Air Force Colonel and got involved in suicide prevention in the mid-1990s with the Air Force. I went on to help write the National Strategy for Suicide Prevention and now I'm the Director of Science and Policy at the National Suicide Prevention Resource Center.

COLONEL CERTAIN: I'm Robert Certain,

Air Force Chaplain, colonel, and previous war fighter. I was a Vietnam veteran and prisoner of war there. I'm an Episcopal Priest serving a church in Marietta, Georgia, and serve on the task force and the Defense Health Board.

DR. BERMAN: Good morning. I'm Lanny Berman. I'm a clinical psychologist by training for the last 15 years. I have served as the executive director of the American Association of Suicidology and I currently serve as president of the International Association for Suicide Prevention.

SERGEANT MAJOR GREEN: Good morning, Sergeant Major Green, Headquarters, Marine Corps.

DR. McKEON: My name is Richard McKeon. I'm a clinical psychologist by training. I'm the team leader on the Suicide Prevention Branch at the Substance Abuse and Mental Health Services Administration.

LIEUTENANT COLONEL BRADLEY: Good morning, I'm John Bradley. I'm chief of the Integrated Department of Psychiatry at Walter Reed

Army Medical Center and National Naval Medical Center and vice chair of the Department of Psychiatry at the Uniformed Services University.

COLONEL McPHERSON: Good morning, I'm Colonel JoAnne McPherson, an Air Force Medical Service Corps officer. I'm the executive secretary for the task force and the designated federal official.

MAJOR GENERAL VOLPE: Good morning, I'm Major General Phil Volpe. I'm United States Army and I'm currently the commander of the Western Region Medical Command.

MS. CARROLL: I'm Bonnie Carroll, an Army surviving spouse and Air Force reservist, and director of the Tragedy Assistance Program for Survivors of the National Organization for Military Surviving Families representing over a thousand families who have lost a loved one to suicide.

CHIEF MASTER SERGEANT GABRELCIK: Good morning, I'm Chief Master Sergeant Jeff Gabrelcik, chief of the Air Force Review Boards for the

Secretary, Headquarters, Air Force.

DR. KEMP: I'm Jan Kemp. I'm the Veterans Health Care Administration National Suicide Prevention coordinator.

MR. TATE: I'm Mike Tate. I'm project manager at Booz Allen providing program management support to the task force.

DR. KINNEBREW: I'm Dr. Cree Kinnebrew serving as subject matter expert on suicide.

MS. STEELE: Sherrica Steele, Booz Allen Hamilton.

MS. CASTELLANO: Good morning, Cherie Castellano. I'm the director of the Cop 2 Cop of the New Jersey Helpline Program.

MR. KOSSEFF: Good morning, I'm Christopher Kosseff. I'm president and CEO of University Behavioral HealthCare of the University of Medicine and Dentistry of New Jersey.

COMMISSIONER ABEL: Good morning, I'm Steve Abel. I'm a retired Army colonel and currently serving as the deputy commissioner for the Department of Military and Veterans Affairs.

I focus on veterans programs in New Jersey.

MS. MILHISER: Ellen Altman Milhiser, editor of "Synopsis" newsletter.

MS. WIENER: Ronnie Wiener, LCSW, Health Net.

MS. RAMSEY: Good morning, Barbara Ramsey, Medical Services International.

MS. EVANS: Cecilia Evans, Aon Consulting.

MS. BASS: Elizabeth Bass, Congressional Budget Office, National Security Division.

MR. MORALES: Good morning, Walter Morales. I am an Army retired sergeant major. I am currently the suicide prevention program manager for the Army.

COLONEL McPHERSON: Good morning, everyone, and welcome. I would like to thank the speakers who have worked today to prepare briefings for the task force. For those in attendance, please sign the general attendance roster on the table outside if you have not done so already. This includes members of the public

and media representatives.

For those who are not seated at the tables, handouts are provided on the table by the registration desk. Restrooms are located outside the doors. Turn left and go around the corner. For telephone, fax, copies or messages, please see Ms. Severine Bennett or Mr. Mike Take. Mike. Mike introduced himself just a few minutes ago.

Because this open session is being transcribed, please make sure that you state your name before speaking and use the microphone so that our transcriber can accurately report your questions. Refreshments will be available for both morning and afternoon sessions for the task force members, speakers and distinguished guests. We will also have a catered working lunch here at the Marriott or here at the Crown Plaza for task force members. Public attendees may wish to consider the restaurant located here at the Crown Plaza or other restaurants within immediate walking distance. I would like to request that no flash photography be taken at the task force

meeting. This may be distracting to the speakers and the public. Also please turn off your electronic devices or put them to silent or vibrate modes so that the speakers will not be interrupted.

If time allows we will take questions and statements from the public at the end of the panel session this morning. We ask that you register to speak at the desk outside this room where you signed in.

Everyone however has the opportunity to submit written statements to the task force. Statements may be submitted today at the registration desk or by email to dhb@ha.osd.mil, and that address is available at the registration desk as well, or may be mailed to the Defense Health Board and, again, we'll have that address available. The address is also available in the Federal Register announcement that was published for this meeting.

Our first speaker this morning is Colonel Retired Stephen Abel. Colonel Abel was

appointed as the New Jersey deputy commissioner for Veterans Affairs in November 2004. In this capacity, Commissioner Abel administers five divisions, the Division of Veterans Health Care Services, the Division of Veterans Services, the Fiscal Division, the Human Resources Division and the Information and Administrative Services Division, as well as the Affirmative Action Office. Commissioner Abel's military career with the United States Army took him around the world from Fort Riley, Kansas, to Korea, Hawaii, and back home again to the States. A more complete bio for Colonel Abel is at Tab 1 in your briefing binders.

He will be assisted this morning by Dr. Chris Kosseff and Cherie Castellano. Colonel Abel?

COMMISSIONER ABEL: Good morning, everyone. We're happy to be down here from New Jersey and we're happy that it's not snowing. Thank you for the opportunity to present to the task force. We think that there are a number of

things that we're doing in New Jersey that are worth sharing with the country and so I think this is one of the steps in allowing us to do so. Our opening statement is actually going to be made by Dr. Chris Kosseff, and then I'll be back up later in the presentation to tell you a little bit more about our connection with our programs.

MR. KOSSEFF: Good morning. Thank you for having us. This is truly an honor for us. I'm Christopher Kosseff. I'm the president and CEO of University Behavioral HealthCare, which is a component of the University of Medicine and Dentistry of New Jersey.

Before I begin my formal presentation I want to frame this about my interest in this program and programs like it. This is not an academic interest for me. I have the privilege of running one of the largest behavioral health systems in the country now but this is a very personal mission for me. Forty years ago this year my mother committed suicide so I know the impact of suicide that it has on families, on

loved ones and have seen people go through the torment leading up to suicide. It's been a privilege for me to dedicate my professional career to finding ways to help people relieve some of the suffering that they go through when they are afflicted with any kind of mental illness.

In New Jersey we have the privilege at the university of having a wonderful collaboration the State Department, the military and Veterans Affairs. This is a critical relationship for us as it's evolved over the last 5 years and you'll hear more about the specifics of that. We have based what we do in New Jersey on a large body of research that exists, certainly not a complete body but it's the best that we have at this point. What we do know about how to prevent suicide we are employing in our Veteran-To-Veteran Program. What we do know is that as standalones, hotlines do very little to prevent suicide. In your packets that we've distributed I have some research support for this and it goes back to 1977 I believe in Los Angeles County and goes up to

some recent studies in 2008 and 2009. It is not that hotlines provide no value at all. That certainly is not true. They provide very much value. But there is no demonstrated efficacy on a large scale that they prevent suicides.

Another issue that we know that has tremendous impact on people is the issue of stigma and how stigma influences people's choices about what to do in terms of accessing care that could be helpful to them. The other thing that we know is the critical nature that families and other social contacts play in people's emotional lives in helping them make good or bad choices as they move forward.

The best that we know from research is that the best that we probably can do is implement multifaceted interventions. No uni-dimensional intervention seems to be effective in and of itself in preventing suicides. As with all prevention research, suicide prevention research is quite difficult to do. Some of the best is epidemiological research, but it certainly doesn't

deal with an individual case. The research does indicate that hotlines for example can relieve some emotional suffering but, again, there is no demonstrated efficacy in averting suicides.

There is some research that indicates the earlier in the natural history of depression in particular that you make an intervention the better the outcome in terms of avoiding suicides and that the best source of assistance is the least-threatening source of assistance which means that for example if you're employed and going to your employer to get mental-health support is probably not a great idea. The more distant it can be from those components of your life probably the less stigmatizing it will be and the more prone people will be to access that case when they need it.

We at the University of Medicine and Dentistry have a long history now of providing various kinds of multifaceted prevention services with suicide and it's a real honor for me to have the person who really has been the innovator in

this for our university here with me as one of the co-presenters. It's a pleasure for me to introduce Cherie Castellano who oversees all of these programs for the university and is really the person who engineered the Cop 2 Cop Program which is the basis of this multifaceted intervention strategy that we now have in our Veteran-To-Veteran Support Program. So it's a pleasure for me to introduce Cherie Castellano.

MS. CASTELLANO: Good morning. I'm going to get right into the topic, and this is one of my passions so bear with me if I talk quickly or with my hands because I'm so excited to be here and talk to you about the peer support component.

I have devoted my career as a master's-level clinician and actually the wife of an undercover narcotics detective to trying to fine tune and learn from this experience with Cop 2 Cop, so I'm going to give you the brief overview and then get into how it translated into the military population.

Back in the mid-1900s there were a

serious of suicides in New Jersey that the governor at the time and a legislator a chief and assembly person got together and crafted legislation. It remains the only legislation passed in the United States called Crisis Intervention for Law Enforcement Helpline Services. What the legislation did was it said that police officers are at such risk for suicide with access to weapons and the stigma connected to reaching out for help traditionally to their careers that they needed a separate service, they needed something unique for them. So 50,000 officers in New Jersey are able to call 1-866-cop2cop and access a retired police officer. Some other data reflects that when people retire they're prone to depression and suicide so this would be a win-win that you would have retired officers sharing their experience back with active police officers to avert suicide and hopefully provide support and care prior to the crisis.

In that context there are four services that the legislation clearly outlines that we need

to provide. The first is peer support on the phone. You could just be a police officer who needs to talk 24 hours a day, 7 days a week. We are not press 1 if you're suicidal, press 2 if you're homicidal. And actually the legislation is funded I should mention from forfeiture dollars. A dollar from every ticket funds the program for the last 10 years. So if you are speeding in New Jersey, we thank you for the contribution.

The four services very simply are peer support, anonymously just calling and saying, hi, I want to talk about what I've experienced and vent with another officer. The second service is a very sophisticated telephonic clinical assessment because the whole model is about peer clinical collaboration so we're able to do a clinical assessment over the telephone, a referral to a customized network of providers and then what we call our Critical Incident Stress Management Services which is really a field activity that allows us to go out and be face to face with the officers.

As I mentioned, we remain the only legislated helpline in the United States for law enforcement. We were thrilled to be certified by the American Association of Suicidology early on. And in our recent site visit we were told we got one of the highest scores ever given by AAS and really stick to the crisis core model and the methodology in our work on the phones. We've had 25,000 calls. We've averted 171 officers with guns to their heads, barricaded, overdoses. We have lost two officers who have been actively suicidal and called the line.

The continuum that Chris alluded to and we'll talk about throughout this presentation is about having a continuum of care, that the helpline itself isn't where we meet these officers. We meet them in field activity also. So after 9-11 we'd only had about a year and a half worth of data and experience and suddenly we were faced with responding to the 9-11 impact that was in our state and with our first responders. We were fortunate enough to receive several

grants. We developed programs for firefighters, EMS workers and teachers. We replicated this model of peer clinical collaboration for a variety of populations, specifically post-9-11. We were recognized in the New York Times as a national model, the FBI and the International Critical Incident Stress Foundation identified us as having the recipe for collaborating peers and clinicians in a safe and effect model.

Post-9-11, of course looking at the response and who was there handling the aftermath, the natural evolution of looking at how we could apply some of these theoretical constructs and experiences to the veteran population in our state was a natural evolution. That leads to my esteemed colleague Colonel Abel coming back and talking to you a little bit about that.

COMMISSIONER ABEL: Let me tell you a little bit about where we were and how we got to where we are today. Post-Vietnam in New Jersey it was difficult for a Vietnam veteran who was suffering from PTSD to get a timely appointment to

deal with his or her issues. In New Jersey the state legislature appropriated money so that we could set up a network of service providers to be able to respond to men and women who were suffering from wounds of the mind in a timely manner. We did that for a little bit more than a decade with the program really not changing very much.

Post-9-11, we established a posttraumatic stress disorder task force, a PTSD task force, and it was made up of both state and federal agencies, the state Department of Health and Human Services. From the federal side of the house, New Jersey is a little bit odd in that it is covered by three VA medical centers and two VA regional offices so we had folks from all of those places join the task force. Our network service providers who had been dealing with the subject for more than 15 years joined the task force as well as members of the New Jersey National Guard, and a network of veteran service officers from across the state who were talking to the veterans

as they came into our offices were making referrals to this network of service providers or to the VA, and at the same time writing claims so that their medical condition as a result of service- connected issues were properly recorded by the VA.

Shortly after our first large deployment to Iraq, UMDNJ came down to talk to us with an offer, what can we do to help you and the guys and gals returning from the war and they described the Cop 2 Cop hotline which Cherie has just talked about. What we decided to do was to model a Veteran-To-Veteran hotline after the Cop 2 Cop hotline and it has been exceptionally effective and when combined with a number of other issues that we will brief you on later in the presentation, we're quite proud to say that of almost 13,000 deployments into the combat theater, New Jersey unlike its surrounding states has not had any National Guardsmen who have committed suicide. That 13,000 doesn't represent individuals. That represents numbers of

deployments. So we have a large number of folks in New Jersey who have been there twice or three times or in some cases I believe we have one who's been into the theater five times now. I think now solely because of the hotline but because of the hotline and other enhancements that we've done, we've got a program that is effective in New Jersey for our National Guard troops.

Our program starts with this 24/7 helpline. What we have learned over the two decades that we have been dealing with PTSD in New Jersey is the timely access to care is important, the ability to talk to somebody who can immediately relate to what you went through is important, confidentiality and sometimes absolute anonymity is also important to a lot of our troops especially those current serving and those who have careers in the law-enforcement side of their lives, and we have quite a few National Guardsmen who work in law enforcement or other direct services to the community.

The services that we provide include

peer counseling, clinical assessments, assistance to family members, and that assistance to family members is during the deployment as well as after the deployment and case management is critical for our veterans and their families. At this point Cherie is going to come up and talk to you a little bit more about those Yellow Ribbon enhancements that I briefly mentioned.

MS. CASTELLANO: Just to give you some construct in terms of data collection, we began the program in 2005. We've had over 7,000. There is some additional data in your folders, there's a lot of additional data, but one of the documents that summarizes briefly is an evaluation of the data collection that we have and then we've had about 12,000 service requests. We do call backs on every caller. When we speak to someone and they call the line, we get permission to call them back. Within 10 days of that initial call we do a customer satisfaction survey and say can we find out of what we offered you really works? Did it stick? What kinds of outcomes do we have. That

way we can track the efficacy of the providers and the resources. There's a lot of calling back and forth so our data isn't just coming in, it's also going out.

In addition, as a result of the AAS certification we were trained that suicide prevention must have you doing outreach and field work and being with the population that you serve, not just the helpline. So again, we had the opportunity to participate in promoting the helpline in the Yellow Ribbon activity and the guidelines and the pre- and post-deployment activity, the reconstitutions and the reintegrations. So over 5 years many of those interventions were originally with us trying to promote the use of the helpline but hearing a little bit more about what the experiences were for the soldiers. What we found was that maybe we could do a better job by standardizing some of the responses in the Yellow Ribbon welcome home and 30, 60, 90. So we created a focus group. We used veterans and clinicians, our typical mantra, and

went in to looking at collaborating, standardizing and integrating to gear up for a big group that was deployed, our largest deployment since World War II in New Jersey, a group of 2,800 were going out in June 2008. So we thought if we're ever going to really get this right and pilot something effectively, we should do it at a point where it's going to impact the most people possible in our state.

So we chose two interventions to enhance with the Yellow Ribbon guidelines, the welcome home and the 60 day which normally has a focus based on the guidelines on mental-health types of issues, OCD, substance abuse and anger. What we did with the welcome home was using the PTSD task force, we recruited 200 volunteers that was comprised of licensed clinicians and peers. Then we trained them with web-based training and academic overview of what to do in this welcome home intervention. So we met one-to-one with every single soldier, 2,400 folks we saw over 16 days using 200 volunteers at Fort Dix in a very

standardized intervention that had a psychoeducational component. We used QPR for the military to reinforce this whole buddy system of identifying suicide once you're home immediately when you're home with your fellow soldier. We did a thank-you component. We got to assess high risk immediately just using the clinicians. And then we promoted the confidentiality of the helpline to defuse the stigma in these one-on-one sessions. We found 199 of that group needed follow-up within 48 hours and we had a mechanism to create a follow-up for care, emergent, urgent, all different types of levels of care. Then we used our information from the 60-day in tracking those individuals to take experiences we had during 9-11.

There is something called the crisis management briefing. To get through it as quickly as possible, it's a large and small group hybrid intervention that allows you to deal with the group and foster resiliency and offer psychoeducation and access to care in a way that's

different than this kind of PowerPoint talking head. It's more psychodynamic in terms of the intervention.

So what we did was Dr. George Everly who was one of the pioneers in crisis intervention, in critical incident stress management service, came in and we replicated a program we had done during 9-11 called reentry with the Port Authority Police Department. Their officers were affected after 9-11. We utilized that experience to design this large group resilience intervention. Concurrently we were doing a survey that Colonel Abel will tell you about in a minute that we did pre- and post-deployment in collaboration with the VA of New Jersey. Then we broke out into small groups in the afternoons and rather than talk at the people who we were serving, we had this co-facilitated peer/clinician small-group discussion utilizing the Yellow Ribbon topics but that was more dynamic. We collected 1,300 surveys and they were unbelievably positive about how this intervention was received.

Similarly, we're trying to correlate that experience in the field to what we're hearing from the veterans who are calling this line. Our data tracking system is very sophisticated and developed over 20 years so we're able to track symptom reports from our callers. We can tell you that the top five presenting problems of those calling the New Jersey Veterans Helpline in aggregate over 5 years has been depression and suicidal thoughts, anxiety and phobias, medical and somatic complaints concurrent, martial and couples issues and PTSD. Some other issues we've heard about more lately are family, parenting, substance abuse which we think is underreported, aggression and violence and recent loss.

Our high-risk callers consistently are the OIF/OEF population right now. About 65 percent of them are requiring counseling follow-up immediately. They're calling us with anger, anxiety, depression particularly with multiple deployments, and marital and family issues, sleep disturbances, long hours, flashbacks. This is all

information that I'm sure you've heard throughout the task force hearings.

At this point I'd like Colonel Abel to talk to you a little bit about how we've used the data to collaborate with the Department of Military and Veterans Affairs and the VA of New Jersey.

COMMISSIONER ABEL: What we've been doing for our veterans has really been maturing over time and so our program has changed almost after every single deployment actually. I already mentioned that we had this posttraumatic stress disorder task force. They have been reporting back monthly or quarterly on course corrections that we should make based on what they were observing in the field in their dealings with the men and women who they were treating. But we also stepped back and said the National Guard and the Reserve forces in the United States are now paying a heavy price to fight this war. They are being repeatedly ripped out of their homes and their communities and their jobs to serve their nation.

So the question for us was how is that going to affect them? Will it affect them differently than the reports that we were receiving based on studies of active-duty troops?

So we teamed up with the VA and a research psychologist out of the East Orange Medical Center, we used Rutgers University to collect and collate data for us and we started looking at that issue of multiple deployments for Reservists. I think Cherie has talked to you about those samples. The pre-deployment sample was more than 2,800, the post-deployment sample was about 800. They are the same people. They are one brigade who went to Iraq and came back last June. The surveys were completely confidential but there were data points on the survey that will allow us to match survey to survey so we'll know these pre-deployment and post-deployment surveys were done by the exact same person and that's proved to be pretty important.

I won't talk about the surveys. The

pre- deployment results are in your folders. The post- deployment data sets are still being analyzed, but two of the things that have popped out in the post-deployment survey sets are about 4 percent of the brigade that went over had thoughts of suicide at one point or another during their deployment or since they're returned, and the preliminary data shows that if you suffered a wound of the mind and you came back to financial hardships, your job was gone, the car blew up and you didn't have the money to replace the engine, those kinds of things, that you were significantly more prone to need help in terms of suicide, drug and/or alcohol abuse, marital or family-related issues.

One example of the data-collection set that we looked at was through the call center. As Cherie mentioned, we collect data on all of the folks who call if they allow us to do that and even before the first article hit the newspaper about the growing rate of suicide in the military, we noticed from the call center that the incidents

of severe depression, and in this brigade more than one-third of this brigade was going back to Iraq for a second time and 5 percent of the brigade was going back to Iraq for a third time and we noticed the incidents of severe depression to the call center were increasing dramatically. It allowed us prior to the deployment to work with the National Guard on a suicide prevention program before they left. The chaplains went over with some training provided by the university so that they could deal with the issue in-country and Cherie has already talked to you about the intense work that we did at Fort Dix before they were released from active duty and during the 30, 60 and 90 day reintegration process.

The helpline for us is the entry point to get immediate service by a trained clinician but there are a broad range of other extraordinary services available in New Jersey and across the country. Of course the key then is to make sure that these services get to the person at the right time, that the right connections are made, because

if they're not made, we often have the traumatic results that this task force is dealing with. We believe that the vet-to-vet peer service system is the right connection, that we can reach out to a broad range of support services in New Jersey again from the state and federal governments as well as from local service providers.

We begin talking to our service members and their families as I said prior to deployment. We continue to work with families during deployment. We help families prepare for the return of the service member because often it is that family member who encourages the service member to seek help as opposed to the service member him- or herself who steps forward and says I've got this problem and I need you to help me deal with it in the belief that by intervening early we will be preventing issues from escalating to the point where they can become life-threatening crisis issues. The helpline and the partnerships with state, federal and local agencies, specifically with the University of

Medicine and Dentistry, an academic institution that has focused on mental health has been just absolutely vital to the programs that we are providing to our service members in New Jersey.

MS. CASTELLANO: To begin to summarize what that looks like, we had some very unique opportunities in New Jersey, the opportunity to have 10 years of experience with Cop 2 Cop and be focused on suicide prevention, the fact that in the Department of Military and Veterans Affairs there was this PTSD task force that had come up with an alternative provider network in addition to VA resources, all of the ability to utilize a very sophisticated access center with automated call distribution equipment and a management information system that was developed over 20 years really put us in a position to be able to do this much more easily than I think a lot of other states which was good timing. The outreach access and follow-up with the program are simply this, that the veteran-to-veteran outreach is at the core of all of this, not just on the helpline or

in the Yellow Ribbon activity, in the community, wherever they are is where we need to be, that this is ongoing support.

We find most of our callers at around six calls. We've had callers in telephone counseling as much as 90 calls over time periods with our peer counselors. But our peer counselors need to be monitored. There are liability issues and there are acute issues. There are clinical issues that need to have the peer supported by a clinical construct.

So at this point today I'm happy to say that instead of just doing the front end for this PTSD network or for the VA, we have this broad system of being able to refer to the vet centers from which we're getting terrific feedback in customer satisfaction in our state about the efficacy of vet center services, to the VA programs that are specifically OIF/OEF that are tremendous and then those community and local services so that it's really driven by the caller and not by who we're serving or who we're employed

by for the resources. And again to have an access center facility to allow us to do data tracking.

For example, we were able to look at where callers are coming from with what symptoms. We knew where the 2,800 were coming home to. We matched that against our provider network to see where there were service gaps and developed that. All of this data allows us to fill in the blanks.

I think I've mentioned a lot of this just in moving along, but it seems to us that anecdotally the veterans themselves both similar to Cop 2 Cop get as much out of doing this work as the veterans are receiving it do so that you have this reciprocal relationship where people are healing and fostering resilience between each other with the safety net of the clinical continuum that's available. We are training and employing veterans every day within this program which is always a blessing. We're able to not develop new programs.

Honestly, everybody jumping on the military service support bandwagon is a great

thing in our state, but they don't have expertise so that we're saying to them don't develop another brochure or another new program. Let's use the services that exist more effectively. And we're reducing the stigma of using veteran peers because they're saying I've been there, I understand, I've walked a mile in your shoes.

I think what we recognize is that there are several opportunities to translate this into other models. I already got to talk to you a little bit about the Yellow Ribbon, but then moving forward again this idea of volunteers being able to support and feel valued in contributing, and certainly in this economy that's a wonderful coup based on the collaboration between the academic medical center in our state, UMDNJ where I work, and the Department of Military and Veterans Affairs.

I'm going to bring this back so that Chris Kosseff can talk to you about some of the overriding successes, but this is just an image. The people look a little smushed there. I'm

sorry. It's the PowerPoint. We developed a stigma campaign we've been using for 2 years now that says life doesn't have to be a battlefield. In this context what we believe is that if you have these examples of information where it's accessible, it's live, it's veteran-based, it's clinically supported, you're in the field, you're on the phone, you're where these veterans are and you're equipped to direct them to a variety of services and not just one of the silos, this is the key to success in supporting veterans in our state. Chris?

MR. KOSSEFF: In the interests of time I think what I'd like to do is make us available to any questions or comments that you might have rather than going on. I think we've presented this well, I hope we have anyway, and thoroughly, and I would to answer any questions that you might have about what we're doing and why we think this is successful.

COLONEL McPHERSON: Dr. Berman, did you have a question?

DR. BERMAN: I was actually formulating a question and I wasn't ready, but that's okay. First of all, thank you. That was a terrific overview. Can you talk a little bit about continuity of care and how you have integrated the service into the community with your professional mental-health resources and what if any feedback you have vis-à-vis how the referrals are taking or not, the quality of care they're getting, et cetera?

MS. CASTELLANO: Yes, certainly. Specifically in terms of the referral process, what we've done in New Jersey is as I mentioned briefly, integrate these services that are offered through the VA, through the vet centers, through the community mental-health system, Military One Source, all of the provider networks that are in our state as well as this unique PTSD network that Colonel Abel has been in existence as an alternative to the service gap. Quite honestly, often we're not able to complete the customer satisfaction surveys at the rate we'd hoped to

because we're getting voicemails and we're not able to talk live to the user as frequently as we had hoped. But the data that we have collected so far is that in our state the most effective services provided right now are from the vet centers based on our feedback from the soldiers.

In terms of integrating our work in the field, we've done things like gotten the State Division of Mental Health Services to allow us to do training to a core of community mental-health service providers who believe that they're seeing a population that might be lose in the tracking of veterans in our state and orient them using the VA experts and the vet center experts and the people who really have done the work with the military so that we're sharing information and we continue to use the PTSD task force as a forum where everyone is represented equally.

COMMISSIONER ABEL: I think the important piece when we're talking about the vet centers is in fact that peer-to-peer piece. We have found the building of almost instantaneous

trust veteran to veteran on the telephone, and then when you make the referral to a vet center where there is another veteran counselor when you walk in, that ability for a counselor be it on the phone or in the vet center to immediately to understand and the veteran to feel that the counselor understands the issues that he's dealing with moves us along very, very quickly in the counseling process.

MS. CASTELLANO: And specifically tracking our field events and activities, when we're present with the population we see anywhere from a 20 to 30 percent increase on the helpline so we know that there is some impact of our being out there.

COLONEL McPHERSON: Dr. McKeon?

DR. McKEON: For this task force our focus is on those currently serving in the military and there are clearly more complex issues in terms of National Guard, Reservists and so forth. But can you just speak a little bit, because you focused more generally and there was a

lot on veterans per se? Could you make a little bit more of that distinction in terms of how you think your programs can assist particularly with folks who are currently in the military or perhaps right in the process of transitioning out? If you can speak to that that would be helpful because that is our specific purview.

COMMISSIONER ABEL: That is clearly a more difficult group to deal with. I was at our Vietnam Memorial just this past Friday. In New Jersey we have a Vietnam Remembrance Day every 7th of May and I was dealing with a West Point graduate who had recently gotten out. I think the key is the confidentiality piece. From all of what we have collected, people are concerned about stepping forward to deal with their problems so I think that's a major issue for the task force to deal with. How do you have somebody who is not wanting to get out of the military, is career oriented but who has this enormous task of dealing with an issue from the combat zone? That's pretty tough and this captain kind of said that.

Our veterans' organizations in New Jersey for a long period of time before all the internet cafes were set up gave calling cards to our troops as they went off to fight the war. We had a soldier from Iraq because he didn't want to turn himself in to the local medic or the local doctor use our calling card to call the hotline from Iraq to get counseling. I think this whole stigma piece is an enormous piece for the military to overcome. How do you do that? How do you eliminate the fear? I'm not sure how you do that. We've done it by creating a system that is absolutely confidential. I think that's the other reason why our troops really like going to the vet centers as well because their stovepipe is also confidential. It doesn't become part of our VA medical record. It's a closed system for counseling.

MS. CASTELLANO: Some of the applications with the active law-enforcement population that have been effective in our state have been things like framing the substance-abuse

prevention within wellness, encouraging crisis response after exposure to specific incidents and allowing for a lot of peer-to-peer activity to be encouraged through chaplains and critical incident stress management services and the psycho-ed, many things that are going on in the active services but I think more of that and focusing more on that to link to a legitimate single point of entry. When I think about all of the telephone numbers that are out there and how confusing it is to look at choices, it's overwhelming to me being new to the military population and so I think about that often also.

DR. McKEON: Is the University Behavior Health Center Access Center the single point of entry? Is that's the way it's integrated.

MS. CASTELLANO: Yes.

MR. KOSSEFF: Yes, it is.

COLONEL McPHERSON: Dr. Kemp, did you want to ask a question?

DR. KEMP: No, he asked it.

COLONEL McPHERSON: Are there any

additional questions? They're not going to be here later on so you're going to have to catch them right afterwards if there's anything you want to ask them. We need to move on to some work on the Hill.

DR. KEMP: I would like to say from the VA perspective you all do magnificent work and we appreciate working with you. We do a lot of referrals back and forth and the vet centers actually refer a lot of their referrals to the East Orange liaison and some other ones. I think it's a cooperative model which could truly be a model for the country eventually. I think veterans need choices just like everyone else and these are great people to work with, so I just wanted to say that publicly. Thank you.

MR. KOSSEFF: Thank you, Dr. Kemp.

MS. CASTELLANO: Thank you.

MAJOR GENERAL VOLPE: I'm Phil Volpe, one of the co-chairs along with Bonnie Carroll here. I had a question. On your first slide you showed that families and social contacts were

critical to this piece besides peer to peer and vet to vet. Could you speak a little more to how you not only make families aware and educate them of the difficulties and the possibilities and behaviors and what are signs of stress and distress and who to call? Could you talk a little more about that training and awareness because it seems to be pretty critical I think in our experience of visiting among the troops too, the importance of family here.

COMMISSIONER ABEL: One of the things that we did with the National Guard early on because we're not on an installation, the installation of Fort New Jersey, 35 armories across the state in all 21 of our counties. A soldier who lives in Camden may drill in North Jersey, and so what we did is created a network of family support centers. There is a major center in Lawrenceville, New Jersey where our headquarters is, there are 10 regional centers and then each of the armories has a family support group. We told our troops you don't have to go

and get treatment at the armory where your husband or your wife works. You can pick a family support group closest to where you live if that is easier for you. You're certainly free to go anywhere you want to. And we've actually invited the Reserve forces from New Jersey to join this family support network as well so that it's not restricted to the National Guard. It is a network that primarily serves Reservists stationed in the state.

MS. CASTELLANO: Specifically, some of the things that we've done in our state thus far, I'll just give you an example, we have worked a lot with Dr. John Violanti over the years in the context of policy suicide prevention and so we had him come in and do a QPR for the military course for the family assistance center coordinators and military chaplains as well as our staff collectively so that the people at the family assistance centers throughout our state would have an awareness of signs and symptoms and be able to disseminate information about suicide warning signs and what they might look for in their own

family members.

We have connected closely to the military family live consultants. They're involved in all of our Yellow Ribbon guideline enhancements so that when we're meeting veteran and clinician together we have those folks who are going to then link to other types of military family live work. In addition, I think that all the family readiness groups, we're there anytime constantly always with an opportunity to talk about suicide awareness, family dynamics, the anger, the impact on the family and then connecting back out to the existing resources. So it's not our primary function, but we're frequently in face-to-face setting with those families in order to educate them and link them.

MR. KOSSEFF: One other response I think is we also have a spouse who is on our helpline so there's a spouse available.

MAJOR GENERAL VOLPE: As a follow-on to that in your experience, and I understand about the family readiness groups and the importance of

that and we're speaking a lot about that immediate family and spouses and those things. But for your single service members who have served, do you have challenges connecting to their moms and dads and the extended family that would be a part of this?

MS. CASTELLANO: We tracked about 30 percent of our calls as family members which are a mix of what you're describing, but we have trouble finding service provision that's covered for them. That is one of our struggles. We don't have struggles having them utilize the helpline and access us pre-, during and post-deployment. We have struggles finding them care that's effective and appropriate when it is a mom, a girlfriend, someone who isn't in that traditional original core.

COMMISSIONER ABEL: What I also was going to say and I am really remiss in not mentioning this earlier, but our relationship with our veteran service organizations in New Jersey is really superb. One of the ways that we get access

to the single family members is by having blue ribbon meetings with their parents while they're gone, and so very often when they return it's the parent who actually brings them to an American Legion post or a VFW post because the parents have been meeting there on a monthly basis talking about their issues, their frustrations of being in New Jersey when their son or daughter employed from Lejeune or Bragg or Fort Sill. That connection when the soldiers comes back off of leave and the veteran service organizations of New Jersey have been there to support his family while he's gone goes a long way also to bringing that single soldier into the mix.

MS. CARROLL: I wanted echo what Dr. Kemp said and thank you all for benchmarking your program with military surviving families with TAPS, and I appreciate the collaboration over many, many years and the guidance that you've provided and the work that you have done behind the scenes with military surviving families already. So thank you very much for that.

MS. CASTELLANO: I wanted to add one last point that I don't know if I got to emphasize briefly which was high-risk groups. In our experience in New Jersey we see the correlation between the military and law enforcement overlay really at tremendous risk. So we get those calls on the Cop 2 Cop line and on the veteran's helpline and we're very interested in offering whatever expertise we have along those lines of what's been effective with the law-enforcement population as they reenter their organizations to serve in both roles. In addition, I think populations like TAPS and the people who Bonnie serve, there are high-risk groups right now that are in dire need of special attention, TAPS also being one of them, the military being one of them. So any opportunity to address that specifically we'd be happy to help with.

COLONEL McPHERSON: Chief Gabrelcik?

CHIEF MASTER SERGEANT GABRELCIK: Again, thank you. I wanted to digress to a statement you had made concerning one of your slides when you

brought up the assistance from the least-threatening sources. This is very curious to me because you had said something along the lines that when you go through this you don't go to your employer. Again we're looking at the full-time military Reserve and Guard, but the full-time military. So do you have any ideas on how we as a task force can push forward an idea to attack where you have the not going directly to your employer kind of mentality to make it less of a stigma?

MR. KOSSEFF: I think that comment was based on research on stigma and overcoming stigma and how people make decisions to access mental-health care in particular. The more distant it is from their world the more likely they are to access it. That was where that came from.

MS. CASTELLANO: Again using the law-enforcement culture and some of the experiences we've had so far with the military that if you can have the employee assistance

resources have some mechanism that is peer based and allows for a policy or directive that clearly educates that person accessing care to what the implications are for them, that that education allows them to be more freely willing to come to you so that if you can combine those two worlds, the peer and the employee assistance, I think that's been helpful in law enforcement.

MR. KOSSEFF: I think more than just what Cherie saying though is that you can tell people that there is a firewall between the health care and their employer, the military in this case, but that doesn't mean that they'll necessarily believe that. And I think to the extent that you can make that a rigid and clear distinction that there is no interface between the caregiver and the military, the employer, is the extent that you can make people feel less concerned about feedback going back to their employer. I don't have the answer for you, but I think it's a critical issue particularly with mental-health care that people actually believe

that there's no feedback to the employer regarding that if you want people to access that freely.

MS. CASTELLANO: It seems to me in the military that you have this tremendous resource with the chaplains, and people sense that that's a confidential and safe place to go, and how to continue to integrate those systems would be really helpful as links I think.

MAJOR GENERAL VOLPE: What are your ideas on how we tackle the dilemma of holding their employer accountable for their well-being and at the same time establishing a system that puts a wall up between the --

MR. KOSSEFF: It's a fascinating question that you're raising because the employer ultimately is not responsible. This is an individual responsibility. When someone makes a decision to or not to access health care is a personal decision and it has to remain that. It has to be their decision. I think other than in extreme circumstances where the law steps in in commitment, for example where there's a legal

decision that someone is incapable of making a decision for themselves and is at imminent risk. Other than that, I think it's inappropriate to hold an employer responsible for the behavior of their employees. I don't think you can do that. If you work for General Electric, it's inappropriate to hold General Electric responsible for a decision one of its employees makes about their own health care or their own decisions whether to live or die. But I think General Electric can foster an environment that provides help to people who are employed by General Electric to seek that help. They can't force it in most cases nor should they.

COMMISSIONER ABLE: Being an old Army guy and knowing that we are responsible for our troops every minute of the day, let me tell you what we did at the 90-day Yellow Ribbon reintegration. When they got off the airplane, every single soldier had to go in and spend 15 minutes with a trained psychologist to do that psychoeducational piece that we talked about. We

did some things at the 30 day. At the 60 day we told you that instead of doing a 1/100 or 1/300 PowerPoint briefing on anger, we put them into small groups of 16 or 18 and we had a trained clinician and a peer counseling in the room with them to talk them through anger, PTSD, drug and alcohol abuse, those mandatory subjects that DOD has said you must cover at the 60-day mark. What we have done at the 90-day mark is we went to the chain of command and we said to the chain of command you've been looking at these guys and gals for almost 120 days now. Which of these guys and gals do you think are not behaving the way they used to behave? But rather than call their name out from a formation, at some time over that 90-day drill they were quietly approached. A fuller psychological evaluation was done and then they were moved on into long-term counseling. So I think the key is that you do it in a way so that their are peers in their squad or their battery or their company aren't watching the process happen and unfold in front of them.

MS. CASTELLANO: Just a quick anecdote. When Colonel Abel had said we saw a spike in some of the calls and we had the opportunity pre-deployment to do a suicide prevention QPR initiative with the leaders of the group of 2,800, we spent an hour and a half answering questions and it was supposed to be a 30-minute briefing because the leadership that was going over with these folks, right, Colonel Abel, wanted to give us scenarios about how they could intervene safely and appropriately and talk to us about how they as leaders could support the people they felt responsible for so that really training them and enhancing their ability during the deployment became something that they were very interested in understanding and I think used effectively for that one group.

MAJOR GENERAL VOLPE: Some of what I'm thinking, let me just think about loud here a little bit, one of the things we hear from leaders, I hear it over and over from leaders, is that they are taking some action on a troop in

their charge but they are not fully aware of everything going on in that person's life because of these anonymous sources of services and care and help that are not shared with them. So there is someone behaving a certain way, a commander who's responsible for what we call in the military good order and discipline because you have to lead your folks into combat, will take an action knowingly but unknowingly know the true impact on the person meaning if they're going to reduce them in rank, somebody does something wrong, and it's hard for them to connect all the dots that the person is also seeing someone for substance abuse, is going off the installation seeing someone for anxiety control, because the stigma they don't want to be seen in the military system so we give them the ability to go off. It's very hard for someone who's taking action on someone and dealing with someone to connect everything going on and understand the full impact on that person yet we do hold them responsible for the well-being and welfare of their people. Can you speak to your

ideas on how this task force can help bridge that?

MS. CASTELLANO: The International Association of Chiefs of Police over a 2-year period looked at updating policy, regional training and education of the leadership in the law-enforcement culture to look at what tracks would indicate what types of action and standardizing that in some way so that the leaders themselves felt clear about the directives, they knew at what point they needed to for sure take action versus adapt their performance expectations and their assignment to those officers under their rank and file. And in that context again much of the focus has been on educating the leadership for the most extreme cases and what the action can be as well as utilizing chaplains, peer-based and other resources to maintain dialogues in task force or open with forums with the leadership so that they're continually aware of that all those other resources are.

MR. KOSSEFF: But I think the General is raising a fascinating question. It's a

challenging issue with sources of help available how is someone to know what's actually going on with an individual who you're seeing in front of you when there isn't a common source of information, a database that that person can draw from? There's lots of stuff that's confidential or anonymous that may be going on that he or she wouldn't know about. It's an interesting question and I would really welcome a dialogue about that because I think it really gets to the core of some of what is being blamed on the military and yet I think is somewhat out of the military's control. They're individual decisions that you don't have control over. You can influence sometimes and that's a good thing when you can influence them, but you lack control and to pretend that you do have control is going to lead you down a path I think that is not going to be a good one.

I would love to have a longer conversation about this because I think it's a critical issue. In the civilian world the same discussion is going on in terms of civilian

outpatient commitment which is commitment to outpatient treatment services and there's a fascinating argument going on now in almost every state in the country and it's trying to control people's behavior and the extent to which you can or can't do that. When you try and control it then you're assuming responsibility I think or there's an assumption of responsibility that goes along with that so I would really welcome a discussion on this because I think it's a fascinating question.

MS. CASTELLANO: But it looks like all of the brother's keeper models and all of the peer-based integral support of caring for each other in this mission in this culture seems to consistently work from our limited scope and so the more you do that at least for the far end kinds of suicides, warning signs and atypical things like all of these models that all of you utilize, assist in QPR and all the acronyms, that more of that could only be helpful I think just from a practitioner's standpoint.

(Recess)

COLONEL McPHERSON: Welcome back, everyone. Our next speaker this morning is Dr. Kenneth Cox. Dr. Cox is a retired Air Force aerospace medicine specialist with extensive experience in military public health surveillance activities. He currently works as a special consultant to Brigadier General Adams, the commanding officer of the U.S. Army Public Health Command, Provisional, formerly known as CHPPM, focusing on medical informatics in support of the Behavioral and Social Health Outcomes Program. Dr. Cox is also a project scientist with the Army study to assess risk and resilience in service members. Dr. Cox?

DR. COX: Thank you and good morning. This request for an update originated back in the January and February timeframe and we've been a little unclear as to exactly what the board most would like to hear from us and the balance between sort of technical issues associated with the ABHIDE versus the way we use the ABHIDE, the

operations and process are both in here but I just mention it because given that originally I thought it would be a 15-minute presentation and it's grown, we have plenty of time to discuss any tangents you might like so I'll leave it up to the board to bring up questions and I'm happy to entertain those in process rather than at the end or whatever your rules may allow. So we'll go through some basic sections here related to the Army Behavioral Health Integrated Data Environment and the way it is being used by the Public Health Command as part of the Behavioral and Social Health Outcomes Program lovingly known as the BSHOP.

Just to lay a little bit of the foundation for our discussion, the ABHIDE is a relatively new application or system depending on how you like to phrase it. It was stood up in early 2009. At the beginning all we had to gauge was cases based on what was housed at the G-1 personnel office. So we had those, and then we had a limited amount of associated data that was

available from the Armed Forces Health Surveillance Center who maintains the Defense Medical Surveillance System which is a relational database with lots of medically oriented facts and such for service members. So we focused on inpatient and outpatient records, encounters that have occurred for those individuals who committed suicide as well as their deployment-related health assessments, so the pre- deployment which doesn't have very much information on it, the post-deployment and the post-information health reassessment forms which do have considerably more self- reported information to look at. So that is what we set things up with. Then to use the parlance of the IMIT acquisition world, we entered into Spiral 1 and this shouldn't be confused with death spirals or downward spirals, these are upward spirals and you're building to the future.

In the first spiral we wanted to expand the types of linked data we had available because of the three primary goals of the ABHIDE and the BSHOP. Maybe I should enumerate those. One is to

establish a registry for first it was suicides and then it was more suicidal behavior as we'll see, and maybe it should be more generally thought of as self-injurious behavior, but we're looking for evidence of risk factors or protective factors. To do that we were limited by just having inpatient and outpatient medical records and the deployment health assessments and we wanted to look at a broader set of administrative data sources that might be available for these individuals. We did expand that to several different areas of personnel, medical and legal and we'll go through those in more detail on subsequent slides rather than right now. This is, of course, part of the Army's task force campaign plan and is monitored closely.

In order to expand the ABHIDE beyond that initial set for deceased individuals which, of course, the rules under HIPPA and the Privacy Act are a little bit different. If you're starting to house and monitor information on people who are still living we have to meet

certain rules and requirements under law so that we did have to spend a fair amount of time establishing those things like a systems of record and a formal concept of operations and the various data use agreements to get the data with each data source who is unique and most of the data sources we're dealing with are outside of the medical community, so personnel, law enforcement, financial, those kinds of those are not as used to necessarily having this relationship and sending their information in to this registry in the sky.

Then we wanted this registry to also support two other aspects of the Public Health Command's work. One is for on-site support, investigations, consultations and such, what we call an epidemiological consult or an EPICON for short, and those have been accomplished at sites that either had clustering of violence or suicide or other things of concern to both medical and Army line leadership. So the information in the ABHIDE can be used for comparison purposes when they go to Fort Carson and want to consider the

differences with Fort Campbell or more recently Fort Hood or as they are now starting a series of EPICONs involving the warrior transition units.

Then the third and least developed at this time objective for the ABHIDE is to support ongoing health surveillance whether that is of a nature to give early alerts and alarms of possible warning signs based on some constellation of factors that we've yet to finish identifying or whether it's more a reactive sentinel event kind of system like we use with reportable medical events or other things, it might be the signs of an emerging infectious disease outbreak or a possible attack involving biowarfare agents. There are several ways we can do public-health surveillance but we have to design a system that will support that.

Our second stage in Spiral 2 after we had expanded the administrative datasets to suicide cases was we wanted to move forward and have suicide attempts and suicide ideations, so that's what Spiral 2 is about. Again, it requires

a fair amount of administrative work to revise all of those existing data use agreements and such to permit us to house that information.

I mention the webcentric part because that's certainly been a big area of work from an information- management standpoint in that right now to get this data whenever you need it with the updates and such usually has to be accomplished manually. They had to write query code and then they have to put it into the system, they have to take it out, they have to package it up, they have to put it somewhere and someone else has to come and get it, sometimes it has to be picked up physically on a CD. It just leads to a fair amount of resource and time.

So this concept of webcentric or netcentricity that's sometimes used as a phrase is that by getting everybody's IMIT systems to agree you can somehow find ways to dissolve the firewalls intermittently and to automatically go out and collect the information you need from each data source and pull it in electronically to your

system and eliminate a lot of the support costs associated with that, but establishing that kind of system and all of the reciprocal needs for security is quite complex and seemingly will take a long time to accomplish but two or three of the data sources are walking down that path and depending on the lessons they learn we hope to incorporate others into that as well.

To move into more of the details of where we are right now, we have expanded beyond the original G-1 list and we've incorporated cases from the Department of Defense Suicide Events Reporting System, the DODSER, and I guess I should stress that anytime we talk about having data from DOD systems, the only data we have is data on Army soldiers. We do not collect data on any other service and it would be inappropriate for us to do so. We have Army soldiers' suicide attempts from the DODSER now. Again, that system evolved over time so it doesn't go back as far for attempts and ideations as it does for completed suicide, hence the different date ranges.

The original nine plus a few extra we've expanded through the revised agreements to include associated information for all three of these categories, and just to highlight in some cases maybe the name is not fully obvious as to what kind of information is contained there, but Army Central Registry for instance involves abuse and I should probably point out that in many of these systems there's the potential to identify people who are victims who would have stresses associated with that, and more commonly though you identify offenders either proven or alleged, again, stresses and obvious problems associated with being correctly or incorrectly identified as someone who has committed one of these events is equally concerning if you're trying to establish either measures for that individual to assist them or for a community where you're seeing signals showing up for multiple individuals in those areas.

The training requirements and resource system to differentiate it from the one at the

bottom here, the digital training, the first one, the ATRRS, is associated with formal school, so this is when people go somewhere to a school to be trained, infantry school or airborne school, things of that nature. The digital training at the bottom is associated with all of the routine kinds of training that are provided to soldiers but is provided at their unit level at their local installation, things like suicide prevention training or sexual assault prevention and response training or equal opportunity training or first aid, all those kinds of routine training that apply to the entire Army but you don't go to a special school to get it, you get it locally. Those again give us information either regarding programs that people have been exposed to. Were they effective? We can check for those kinds of things in the training section.

Then in the middle there, the centralized operational police suites and the Criminal Investigation Division work which are on the legal side, the law- enforcement side and give

us information about people who either committed infractions of one type or another or have been arrested or given tickets. The vehicle registration system is not to know whether they have a car or not but there is also motorcycle registrations in there and some question about whether that might be a viable thing to monitor from the standpoint of a risk factor. And of more interest buried in the vehicle registration system are the weapons registrations for people who have purchased and have permission to keep weapons at home of their own and not those issued to them by the military. So sometimes inside of a different title you can find more important information to look at.

The Defense Casualty Information System of course is pretty obvious. That's for mortality data from Casualty Affairs or people who are injured but not fatally as well, and that gives us a large range of things to look at there.

Moving on, we talked already about the DODSER group and that we have the cases of

suicide. The nonfatal cases are not complete and I think that sometimes gets forgotten in that it's only those who needed hospitalization and/or evacuation through the fixed-wing air evacuation system. We at this point at least have not done a comparison study trying to look at ER data and other sources that might have what appear to be less serious potential suicide attempts and what proportion of those don't get hospitalized, and certainly in my personal experience most of the time even what was maybe inappropriately labeled as a gesture in those does or something that wasn't quite as serious might well still have been hospitalized for a day or two, so I'm not sure that the missing cases are a large number but it's something we do plan to address and investigate.

The Drug and Alcohol Management Information System does give us some information about potential drug and alcohol abuse, both the results of routine drug testing or testing for cause, and then of more interest is that it also captures whether the people made the connections

and were entered into a counseling or therapy program and whether they stuck with it and what was felt to be the final outcome because much of that is not captured in the medical data since it's not handled as a medical situation. The personnel database of course gives you all kinds of information that's demographic and career history progression, promotions, demotions, things of that nature. Then the Medical Protection System gives us information that again is mostly medical and we've already talked about the deployment health related assessments, but this is actually an error on those slide. It turns out that the data use agreement hadn't quite been finalized yet so at this time we're still getting those deployment health assessments from the Armed Forces Health Surveillance Center but we will transfer over to the medical protection system in the near future.

Those previous ones we talked about were for all three categories of suicides, attempters and ideators. This is a group that we're still

working through. It's currently limited to completed suicides but it won't be for long because the Clinical Data Mart and the military health system are primarily the output from our electronic health records, AHLTA and the military health system. And we have just completed the revised data use agreement as of a week ago and so new data is being generated for us that will capture these other groups that were missing so that within a couple of weeks we'll be able to move those two to the previous one. As I mentioned, the Defense Medical Surveillance System is on its way out. We don't need to get the data from them now that we can get it from another source that's consolidated with other types of data and reduces some of the administrative burden.

Beyond that there are other data types that we think may be of value and haven't had a chance to work with them yet or characterize or analyze them and have divided those into two sets, some that we already know that we're going to

pursue which are the ones on this page, and others that we may depending on either additional information we collect or the results of the Army Stars effort. Again one of the reasons they thought it could be useful to have me here is that in addition to these ABHIDE details, we are supporting Army Stars and there are a couple of Public Health Command staff who are project scientists with them and we've been doing some collaborative studies and analyses.

But to look at the other Spiral 2 data sources that are on the future timeline, we are looking at safety management information. This is the system that captures the major mishaps or incidents, accidents or whatever phrase you're willing to accept, a helicopter crashes and it's destroyed or people are killed, anytime there is major loss of millions of dollars and/or loss of life or limb then it has a formal investigation through the safety system and each of the services has a center that's responsible for that, and with the Army it's at Fort Rucker. Much of that

information though which is narrative in style in many cases is protected because of the need to ensure to the individuals that they give the most accurate and complete information so we can learn from that and avoid the mistakes. So it's not fully releasable and it's not clear that we'll able to gain as much as information as we might like from that.

Army waiver data is specific for when people are joining the military service and that's of course received a fair amount of coverage in the media. We do change our decisions with regard to waivers depending on the recruit environment and that's a necessity in an all-volunteer force, that if you don't have enough volunteers but you're required to field a certain number of units and be at a certain level of readiness, sometimes you can adjust the thresholds that you're willing to accept. So questions about education level or past infractions with the law, different types of misdemeanors and felonies so they can get what's called conduct waivers so maybe they had lots of

traffic violations and speeding or maybe they had some other types of legal infractions, and although we might normally say that's not acceptable to military service, we sometimes give waivers depending on the story, the case, the evidence and what's presented. So they're looked at on an individual basis. There are administrative waivers, there are conduct waivers and then of course great interest is medical waivers for conditions that are known to exist.

The final category is drug and alcohol waivers. I put that at the bottom of the list right now because that's the one that we're least likely to accept people for infractions, known drug abuse or alcohol abuse and problems of that nature, right now it's closed. If that's on your history of your record you will not be admitted. But it does open up in some cases when the recruitment is very low and again how they do that, the exact way, what level they accept I don't know the details of that, that's a personnel function. But the medical ones would mean history

of depression, major depression treated X number of years ago. More commonly it's things like asthma, so somebody has a history of reactive airway disease as a child and then it disappeared and hasn't come back in some many years and they might well receive a waiver for that to enter into active duty. But that whole program gives us some insight into the types of conditions that are being accepted and whether they might tell us something about eventual outcomes for the individual soldiers.

The contingency tracking system gives us deployment histories, who went where, when and for how long. Then the more personnel from the DEERS system is primarily to understand relationships over time. Most of our personnel systems overwrite information. They're only interested in the current most accurate information and all the historical is not maintained. But because of the DMDC being identified as the actual official archive for personnel information for the DOD, the various feeds that come in each month to them do

get saved and so you can piece together a person's history of relationships throughout their whole military career. You can know when they got married, when they got divorced, when they had a child, when they had someone who died, when they got remarried for a second time, et cetera, and so you can create that chronological timeline with a little bit of effort.

The physical disability case processing is again a personnel system. It's after we've identified a health or medical condition which is normally disqualifying by the existing standards in the military and they've gone through a medical evaluation board and it gets forwarded to the physical evaluation board for a determination whether that individual will be retained on service or not.

Then finally the last two, TRACES is to give us information about individuals who had to be evacuated to make sure we're capturing all the suicide attempts that should be in the DODSER and things of that nature, a cost validation check.

The Wounded Warrior Accountability System is a relatively new application as well that seeks to capture a large amount of information about soldiers who are assigned to warrior transition units.

The ones that we're less sure will turn out to be of use and/or have certain technical limitations that prevent us from pursuing them aggressively at this time are listed here. The Army Court-Martial Information System and the way it lags by 6 to 12 months, and we probably already have information that leads that as an indicator from the carious criminal investigation reports and the military police reports, so this would tell you the final outcome of that a long time later. But as far as being an indicator of stress on the individual at the time and knowing that maybe there should be some protection offered or special programs or other contact is far too late to be of assistance. The ANAM of course is grew out of traumatic brain injury concerns. We would be interested in it primarily from the standpoint

of a baseline for neurocognitive testing that we could look at over time and relate it to other things which may or may not involve TBI.

The Soldier Fitness Tracking Program is the new name for Comprehensive Soldier Fitness and it again allows a chance over time to piece together how people's responses change to a certain set of relatively standard questions that cover a wide range of psychological scales and measurement, depression scales and alcohol use and things of that nature. You'll see that we cover those in the deployment-related assessments that we've already talked about, they come up here which is supposed to be an initial one sometime in the basic training environment and then annually thereafter. Then there is also the annual periodic health assessment a couple of bullets down. All of those have a core set of questions that are identical or very similar that cover this same kind of set of domains that we could then see over time how things are changing and look to link that or relate them to this other types of

information that are available for those individuals.

Finance accounting I don't think will pan out as we'd thought, that it might be a way to see when people are having their wages garnished or something that might be again a sign of a financial stressor as one of the known risk factors for suicide or suicidal behavior. Most of that information doesn't really get captured in a way that we can use it.

Then of course sexual assault is another example of a system that will allow us to find both victims and perpetrators. And the theater medical store is for deployed settings, the inpatient/outpatient and ancillary information such as medications prescribed in those settings, laboratory tests ordered, et cetera. All of that is of interest but is entirely separate from our more traditional MHS data sources and will take a fair amount of work and manipulation to be able to access and use that data.

That covers the types of data that we

have or that we hope to get. Then we've identified these particular challenges in addition to others. One is related to the nature of establishing these kinds of registries and electronic systems now and it's become more and more complicated and some of that is reasonable and it's important to safeguard privacy and information security and all of those things, but also it's become fairly difficult from the standpoint of attracting funding and being able to make relatively simple changes or to enhance the operations without going through a great number of steps and requirements and documentation. So we struggle with that and live within the rules but wonder if that's not a way to simplify things at some point.

We still have the index cases as we've mentioned that are limited in some ways and we may expand beyond just the hospitalized and the evacuation-related attempts and ideations assuming we can find good sources of that information that's accurate and can be interpreted. The real

struggle with having only index cases is that for a registry that's fine for counting things, it's not so good when it comes to rate calculations, monitoring over time or surveillance. We really need control groups. Then you run into how to clearly differentiate between what is appropriate for public-health-oriented surveillance which is the Public Health Command's mission versus research which the Public Health Command can do but we don't do much of and if we are going to label it as research then we have to go through IRBs and protocols and all of that as opposed to more simplified surveillance activities. The controls and comparison groups for each of those activities are not necessarily the same. The ability to take the whole community as a control is of course a popular approach but then you run into storage issues and a lot of other things about constantly getting data from all of these sources on every single member in the Army. So that's one of the things we're struggling with now and we're looking at other types of registries to

see how they deal with controls. Currently we've gone with a go out and get a control group that's most appropriate matched on the necessary criteria for the specific task at hand so that with Army Stars we're performing a suicide case control study using these administrative data sources that we had already had in the ABHIDE. So we went and obtained a limited control group with a 5 to 1 matching, five controls to one case, and then matched them on certain criteria. As soon as we got done with that we found that it wasn't going to work for other types of things, so again we either have to have everything available to create our subgroups for comparison or we have to have things like net centricity established so that you can easily go out and get it just in time without taking 3 or 6 months to get that data using the current difficult process of data use agreements for each new project, study or analysis. Again, a good challenge and we're addressing that.

The last ones are more standard for every type of thing whether it be risk

communication, whether it be making sure that commanders know the limitations of what we have and that even though this is electronic data, it takes a lot of work to get it and it takes a lot of time to understand it. So the fact that we have a lot of data stuck in a server now doesn't mean we can push a button when every question comes up and provide an answer within an hour to satisfy Congress or anybody else so that we certainly hope that people can help get that message out. As we go along of course we learn more and response times can quicken, but we're also still bringing in more new data and things too so it's pretty much an evolving situation.

The last item is one that I've warned the Public Health Command about, it hasn't been an issue yet, but as soon as people understand that you have an archive like this, a registry and the types of information that's in it, it becomes both of interest and potentially valuable to have other researchers have access to it. To provide that kind of access requires that you establish the

administrative support and the bureaucracy to go with it so that we have to have a way to establish data use agreements. We don't have that now. How would we share the data? What would limitations be? So it's on our list of things to produce but right now we need to get operational first within the Army and that's the way it's established now. There is no external access to the ABHIDE data and there won't be any in the near future, but I think there will come a time that that will be appropriate and it could well be to external researchers too just as we do now with MHS data with Army Stars. We have a consortium of military and civilian academic institutions and they've come together and we're providing them with data so that they can do analysis.

That closes out the prepared material. As I stated at the beginning, I'm happy to entertain questions or go off in different directions as you desire.

COLONEL McPHERSON: Thank you, Dr. Cox. Dr. McKeon?

DR. McKEON: Thank you for your presentation. I have a couple of questions. The reason behind these questions is at least if I understand correctly I think that the ABHIDE system is the only one at least for the Army that has certain kinds of critical information in my point of view having to do with behavioral health utilization patterns for people who have died by suicide. From the earlier briefing that we were given 4 or 5 months ago I guess, the data that we had seen in some presentations from your staff members at the AAS conference, that there were, and correct me if any part of this is incorrect, but 15 percent of those who died by suicide in the Army from 2001 to 2007 from the data set had a history of inpatient psychiatric hospitalization, 45 percent had a history of behavioral health care all within the military not counting what may have happened before. That was my understanding. Is that also your understanding of the data?

DR. COX: I don't remember the 15 percent inpatient, but I might have just missed

that one. Certainly the 45 percent -- and one of the things we've struggled with is how to best term it, so whether it's behavioral health care or whether it's behavioral contact, we haven't finished analyzing that yet. What we had is that individuals had appointments in a behavioral health clinic setting, but whether they were truly in treatment, whether it was just an evaluation to rule out something like PTSD and they only had one visit, whether they had multiple visits, some of that they're looked into but we actually have a second layer of that and that's the case control study that I mentioned so it was based with this limited control group of the 5 to 1 and not the Army and we weren't able to tease out from the data we had whether the provider they saw was a behavioral health specialist or whether it was a family practitioner or primary care practitioner. So those are some of the things we want to look into and analyze and be able to report before we go too far down the line. I don't know how to interpret the 45 to 50 percent having had contact.

In some ways that seems good. It means if there was stigma it wasn't enough to keep them out. But at the same time, we know people are going to stand up and be detractors and say if 50 percent of your people had behavioral health care and they still killed themselves, obviously you have lousy behavioral health care. That's the part that I don't think there's any evidence for and that we need to do the second- generation look to figure out.

But, yes, those are initial findings and some other ones like the deployed environment which again is a limited set of data and a whole other set of challenges, but that risk seems to be greater for people when they're deployed and in the post-deployment period as opposed to the pre-deployment period. I'm not quite clear now that works out or plays out for when you have people who have been on multiple sequential deployments with some varying interval between them kind of thing, and the rest of the study found just reiterations and further validation of

well-known facts such as the younger age groups, the recruits, the first 2 years of military service and some other periods that have already been found to be higher risk than others.

DR. McKEON: Let me follow-up on that. I would agree with you entirely that those numbers do not say anything about the quality of behavioral health care received and it would be a significant error to make the judgment that the quality was inferior of that data. It would also be a great error to assume that there are not opportunities for lessons learned that can be taken by looking more closely at that information.

The specific question I had is that in terms of looking at some of these patterns, will you be able to look at questions such as whether someone had been seen within 7 or 30 days, for example, of an inpatient discharge or of a behavioral health contact, whether it was evaluation or for treatment; or, for example, whether someone may have just stopped going to treatment in the past -- will you be able to

analyze that? And is there anything in the current system that will allow for this kind of data to be fed back into the military mental-health systems for them to learn lessons whatever that might be to improve?

I think also that this is an area where the comparison issue in terms of a control group isn't really relevant because we know that there are huge issues in the civilian population so that being the same as the civilian population would not really tell us anything other than that potentially there were opportunities for improvement in both sectors. Will there be a link to go from a research environment to quality improvement? Again I'm not saying that the quality is poor, but being able to look at this from the perspective of learning lessons that can help systems evolve?

DR. COX: I think the answer is yes but the details are difficult. Certainly from an administrated data standpoint we can analyze the health encounter pattern and we can look at that

relationship to the date of the event in question whether it be a suicide, an attempt or hospitalization for ideation. That's what we're doing now and we're looking at the various types. They had mental- health clinic visits but those mental-health clinic visits were 18 months before the event and here are the other people who had them within 30 days of the event. Yes, you can evaluate, but it becomes more painstaking, and it's not so much administrative data that you can evaluate the quality of the care, you're going to have actually look at the full medical record and you'll have to look at the narrative and the text parts as opposed to what's computable and that's where it starts to become much more resource intensive but that is all part of the BSHOP's plan and other groups too.

Yes, we're looking for the lessons learned and we need to tie in and the point is to give feedback whether it would be prospective in real time using a system such as we have for the DOD called ESSENCE which is a syndromic

surveillance approach for infectious diseases to identify outbreaks. That same system I've suggested there is no reason, it's based on ICD codes that are applied at health encounter settings by the providers, and you can have a behavioral health module of that if you wish and you can identify certain diagnoses that you think are important and you could construct patterns. You could say if somebody was given a diagnosis of PTSD and they were only seen for two visits, does that send a report to that cite for the chief of hospital services or clinic services to say was that maybe a lost opportunity? Should we try and reengage? Of course all of this is always being balanced against the right of the individual to not accept offered treatments or consultations so I'm not sure how that will all play out, so you understand how it's complicated.

But that is the goal is to see what we can extract from this that's useful and certainly the patterns, whether medications were given, whether this type of treatment was given, all of

that leads to some ability to judge the quality of care and to create a feedback loop to the local providers.

COLONEL McPHERSON: Dr. Berman?

DR. BERMAN: A related set of questions. On one level we've heard a lot about different surveillance systems and data-collection systems and integrated systems. Some of the problems I have with them is the nature of doing research and we start computer rising in integrating emerging various data sets is that you lose the dynamics and the liveliness of the individual case that you can then aggregate so that you can understand for example the pathways from relatively functional to dysfunctional to suicide. I'm curious, for example, in the data sets that you have, if I wanted to know what have you learned about the last 7 days of suicides' lives that would help us translate that data into training messages vis-à-vis what to look for, what are the most commonly observed behaviors, symptoms, signs, cues or whatever? Is there anything of that sort that

is available through this kind of model?

Before you go on, a similar problem I have with some of the data-collection systems particularly around behavioral health and mental health is that they focus a lot on ICD codes or on diagnoses and we lose the focus on individual symptoms and constellation of systems that may be subclinical, they may not add up to a specific diagnosis or disorder. If I wanted to know more about symptom presentations and observations, would this system allow me to learn that?

DR. COX: I can never remember more than one question at a time. The first one was the issue of aggregate data and being able to see the evolution or the last stage prior to the event, and I think you mentioned the 7-day interval. The issue with administrative databases is that you're limited to what gets entered into the administrative database so that if the individual doesn't come in for a personnel transaction, doesn't get arrested by the police, doesn't come in to see the clinic in the last 7 days, the

administrative data sets give you no information about the last 7 days and that is what you face with this. To get that information usually involves looking at interviews, talking to family members, more human based and on site. The only one of these systems that comes close to that and it falls short at this point but could do significantly better with additional training and compliance is the DODSER where you have a requirement for a behavioral-health professional to look at that case and to find information including a focus on the recent past. Then that gets entered as free text which again is tough to deal with even in today's character recognitions and all other things, free text is just awful to deal with from an analytical standpoint, but that's a system where at least you could open up for a given individual and you could read this and you could get some of the flavor of what you're asking about.

But to do that consistently over time with different cases will require rigorous

training and acceptance and understanding and compliance with entering the information and you will unlikely gain any kind of a comprehensive picture from using the administrative data sources to do that. Maybe I should reiterate that we don't see the ABHIDE as being magic and answering everybody's needs.

Tying in with your second question which I'm not sure I remember all of it right now but it was about administrative databases and it reminded me to say that none of these databases we use were designed for this purpose and that's been a public-health challenge for a long time. We don't in public health get resourced to produce unique systems that support our goals and objectives and the only way we can survive, and this is on both the national civilian level as well as in the military, is by leveraging existing systems that were paid for to support some other purpose so that the medical ones and ICD-9 codes now, and you were asking about symptoms, if I talk around things long enough I eventually get a clue to what

it was -- but the health care systems we have are designed to support medical administrators, hospital administrators, people who have to decide what kind of budget is necessary, the resources, are there enough Band- Aids, do we need more orthopedic specialists. They weren't designed to support public-health surveillance. But we can get a fair amount of value from it with some assigned uncertainty range around it and we've learned to do that so that the MDR and CDM we mentioned give us that.

Yes, it includes ICD-9s. Those are computable and we often start with those, and in some cases we've been able to show through formal scientific analysis that they're quite good for infectious diseases even knowing that providers are not well trained in assigning ICD codes and all these other things. It still works even with those problems. We don't know that because we haven't tested it yet for the behavioral-health environment and that's some of the things we found with that case control study. Yes, there are lots

of people who get thrown out a diagnosis of depression and they're seen one time and they don't get any medicines or they get a prescription written but the person doesn't fill it and then we never follow-up and they never come back in after the first visit. What does that mean? Are they lost to care but they still had a problem? Did they not have a problem? Did they get enough reassurance from that individual that they didn't need any more support unless something else happened?

Some ICD codes of course are for symptoms not so much on the psychological side of the house. Those are mostly physically based symptoms, but there are some. Then, yes, there is the concept of using either the MEDCIN terminology from a health encounter. This electronic health record has two ways that people can enter information.

This, again, assumes the individual has been seen by somebody and is not just talking to the chaplain or something which is a whole

different world and not usually captured electronically at all with different rules about reporting and release. But for health encounter records somebody sees a doctor, they have to then fill out their history of the present illness and they do that in two ways. Either they can free text it or they can use what are called MEDCIN terms, and they're numerical terms that give you a generated phrase instead of having to write it by hand and you can pick multiple of those and they get strung together and it creates text. Those are a lot easier to compute. It's a generational kind of thing though. Most of the older physicians who have been in the service a long time don't want to use the MEDCIN terminology and they want to write it in by hand. That's what they learned and that's what they're comfortable with. The new ones who have been playing with their thumbs and sending IMF text during oral exams throughout their last 20 years of life are very happy to use MEDCIN terminology. The point is that by analyzing the narrative parts of health

encounter records there's more information along the lines of symptoms as opposed to what some individual decided was the diagnosis whether it be a working diagnosis, a final diagnosis or a diagnosis of exclusion kind of thing. So some combination between those probably gets us farther down the road from where we are.

MAJOR GENERAL VOLPE: I have a question. I saw all those databases that you either are using or are rolling out or are considering to use to get information. Are you using any VA database feeds? Where I'm getting to is what's the source of information or statistics that you get on really anyone who has served in the military? One of the things that we sort of struggle with is trying to figure out whether someone who committed suicide, could it be tracked back and related to their service in the military. We can't even get to that point unless we know that they served in the military to ask that question. If someone were to ask the question of all those who served in the Army for the last 10 years at any point,

how many people have committed suicide whether they're active, retiree, ETSed veteran, whatever category, is there any way to collect that information or anything that feeds back or any ideas that you have on how that would be done?

DR. COX: I have yeses to all of those but no to the first question. Currently on VA data is being used at least at the Public Health Command to do this work. I can explain why that's the case. This goes back to my health affairs days. I've long sought a more dynamic exchange of information and back then I was responsible for these deployment health assessments among other things and so we were knowing that individuals especially Reservists would choose to seek their care from a VA facility because it if anything might just be closer to where they actually live since they're not all stationed at active military installations. But we were never able to get there and so we wanted to know who was being seen. It seems to be part of occupational medicine. We need to know whether it's safe for them to be

doing their job and the VA felt that that was an invasion of privacy and that they couldn't tell us that someone was being seen and possibly treated for depression or whatever, PTSD. So that's an ongoing political issue between the two groups.

Certainly we continue to talk at high leadership levels about how we're going to tie all those systems together and the electronic health record will be seamless and we'll be able to get to both things. From my perspective that's working better for physical-injury cases. I don't see it working well for mental-health and psychological cases, but we need to get there.

There are things we can do now even lacking though, and I don't know how long that will take. We've been working on the Bidirectional Health Information Exchange and the coming CHDR and all these other things that are going to do these combinations and sooner or later I guess we'll get there. But as far as fatal events, there are systems that can handle that. Sadly the DOD as I've mentioned to the Defense

Health Board and its predecessor the Armed Forces Epidemiology Board in the past, we have failed to have the foresight to establish a full-service Department of Defense mortality registry. It's not hard to do, not even very expensive. And to further sweeten the pot I've said it's silly for the VA to create one because all of their beneficiaries come from ours, we would be the universal one, so it's very easy to create to combine a DOD/VA mortality registry, a single one and look at all the resources you save.

If you had that kind of a mortality registry, it could include not just people on active duty but Guard and Reserve even in inactive status and people who have separated. We don't have that. That's the short answer. We never have. It's been proposed several times. I've tried to put it through at Health Affairs but no one could come up with the funding and so things like electronic health records or for the time influence surveillance, there are always priorities, but a very standard piece of the

public-health word that's been successful and useful for centuries we haven't ever established. That's one soapbox of mine and now I'll step off of that one.

But what we can do in the mean time paying money each time to do it is we can use the National Death Index at CDC. We can take our Social Security death tapes. We can identify from our personal records people who have separated. Our shop up there is doing that right now as a limited-focus study to look at deaths in people in some period of time after they've separated and to look for those missing suicide cases. How you're going to interpret that is still going to be tough. If they commit suicide within 30 days that's one thing. If they do it 3 years later, I'm not sure I'm going to say it's part of the military's fault or result. Without a lot more information you can't really get there and people will want to make those conclusions though. So this is another one of the two-edged swords to deal with. But the point is there are systems

that do allow you to identify deaths.

Suicide attempts and ideations will be much tougher of course unless people have a residual -- if they're retirees who can be seen in our system or we have some way to look at it. And I guess the other thing I didn't say, all of these systems that we've designed are most useful for active duty. When you talk about the Guard and Reserve, including those in the Selected Reserve who are currently on military service, we just don't have access to those.

And even getting the information on deaths is quite challenging, and I'm working through that now trying to get the Reserve Personnel Center, they have to find out, they do because they turn of entitlements, they stop sending checks. They find out people have died, but none of that seems to go to the central system, it doesn't come up to the Armed Forces Institute of Pathology, they don't necessarily get any information from the local coroner and medical examiner and so we have a big cloud around those

cases and we don't know much about them, but we could do better in that area and we're going to see what we can do. But I do think a morality registry would be a big step toward understanding the death side of it better as well as all kinds of other deaths of course and not just suicides, but that's a different issue.

And sooner or later we should have access to the VA data. Some of the challenges include people being seen at the vet centers which have a different system and may not even collect the data electronically. Then you have the VISTA and the health encounter data at the VA clinics and hospitals which should be easier to get. We do have one site, Great Lakes, where they've of course combined the VA and the DOD and they're sharing providers, they're sharing electronic systems, they're sharing facilities and we have limited partnerships at other places with this Bidirectional Exchange, Albuquerque, New Mexico where they share the facility there for inpatient care. So there's some movement but not nearly

fast enough to satisfy most of us.

MS. CARROLL: Could I ask you a quick follow-up question? For the Guard and Reserve, most if not all have SGLI services, group life insurance and when a suicide occurs not in a duty status SGLI in most cases will pay out. Are you checking SGLI payout data to track back to the deaths not in a duty status of Guard and Reserve?

DR. COX: The short answer is no. I have tried to deal with the life insurance data in the past but mostly with the traumatic service group life insurance policies and that was identifying seriously injured people and some of those other issues. As I recall, that is managed by the VA, the data for that. So again that puts it back into getting the VA to agree and then creating the agreements. It's hard to establish all these data use agreements within the DOD with other DOD organizations, but as soon as I have to step outside the DOD it becomes really hard.

MS. CARROLL: The program itself is administered by the VA but the application process

is through the DOD.

DR. COX: I've made a note. We'll add that to our list of things to find out about. I don't know what the rules are. It's sort of like some of the financial ones and there are some projects that are looking to see if they can check credit ratings through those commercial systems and get information that might tell you that somebody has a financial thing. This is not related to that but it's still financial and it's still personal and family and benefits and so I have to tread lightly, but we'll ask some questions and see what we can find out. And the personnel office may have some because they're involved with that too. They have to keep the records of who asked for what level of insurance, what they accepted and who the beneficiary is so that should come out in my discussions.

LIEUTENANT COLONEL BRADLEY: I've got three-part question and I'll break it down into one-part bites for your benefit. We're all in search of the Holy Grail of finding the positive

predictor for suicidal behavior. The questions are, what data sources specifically do you use to identify the suicide attempt behavior and suicide ideation behavior? Is that through the DODSER and admission, the COPS and the CID information management system or are there others in this amalgam of systems that you use to identify prefatality suicide behavior?

DR. COX: We're still making our final decisions on that. Certainly right now the official one that we rely on and that the studies have used is the DODSER. So if people had an entry in the DODSER then that was the gold standard. It's not a gold standard and we have done the validation work to show that. Dr. McKeon may have seen some of that at the AAS because I was helping with that too. But we looked at inpatient records from the MHS and then we used the E code which is specific for suicide attempts that have been identified, then we looked to see if those individuals had a DODSER to go with them and the correspondence was low. It was around 20

to 30 percent as I recall. And the reverse was also true. If we had a DODSER and then we went and looked for the either air evac or hospitalization to go with it, it was about the same concordance, around 25 to 30 percent at most.

LIEUTENANT COLONEL BRADLEY: I'll head into my follow-on question. What recommendations do you have for the military health system to code more accurately suicide attempt behavior and suicide ideation, particular CPT codes, E codes? What would be most useful for this data-collection and analysis piece?

DR. COX: I've dealt with this from the standpoint of injuries in general and this was an ongoing problem in the military health system, that we didn't provide E codes. We diagnosed the fractured leg or the sprained ankle or whatever but no E code. And we fought for years to establish a pop-up box so that when a provider coded for an injury if they failed to include an E code then they got one of those dreaded irritating pop-up boxes that said, excuse me, you forgot.

Please assign an E code and here's the link to take you to them kind of thing. Providers object strenuously to any of those and they fought it for many years. I'm still not sure it's actually out there, but it is official, it's on the requirements list, it's been built and it's coming out sometime soon to a theater near you and it will be there. You could adapt that to this because I would contend that it's not so much the accuracy, it's the consistency.

So if you look at the codes for where the DODSER existed but there wasn't the hospitalization with the E code we could certainly find maybe a hospitalization that had superficial cuts to the wrists or asphyxiation or something of that nature that led you to believe there could have been an injury that might have been self-inflicted but you couldn't get there just by using the E code. I think that is an easier sell than CPTs because they're a little less specific. I can't think of one that would be great for that.

LIEUTENANT COLONEL BRADLEY: The one

that's available in the system with regard to suicide is suicide risk which is a generic 399 code which is used for multiple things. It's the all other attachment but it's assigned to suicide risk so that's a problem.

DR. COX: I think if you had good E code usage that that would be easier to sell because CPTs don't drive anything for providers and it's very difficult to get them excited about that. It's not the civilian world where they don't maximize their return from the third-party insurer or Medicare or Medicaid by having accurate lists of procedures so we don't train our people to do that and they don't have any impetus to do so. The E code though should be important and is easy and there is this thing coming that could be used by just coding the right things to go with it, but how do you do that? It's not necessarily an injury so how are you going to get the warning box? I don't know. Then you're back to training.

Yes, we can train groups of people, at least the psychiatrists and psychologists with

inpatient privileges and focus on them maybe and they should at least be consulting, and that was the other thing. A lot of these cases get admitted not to a psychiatric ward or hospital, but because of the injury they've got to go into the medical surgical side first. Then when they're stable they may not even stay in the military hospital. There are some sites that send them all off to a civilian.

I guess I forgot to mention for Dr. McKeon's interest, we do look for the purchased care as well as the direct care when we do these analyses and we have that available those with TRICARE benefit. Obviously if it's a Reservist on an active duty and they choose to go see a drug rehab center on their own dime, we don't see that. But if they use TRICARE then we can find those purchased care events.

LIEUTENANT COLONEL BRADLEY: The last question again in search of the Holy Grail here. In recognizing how imperfect your data analysis may be with case controls and it may not be to a

scientific standard, what does your multivariant regression analysis indicate so far for completed suicides as the things that we as a task force and clinicians and leaders in general might be looking for as the most proximate causal factors for suicide?

DR. COX: I'd probably have to demur on that because that analysis isn't finished. They are working on a report and it will be releasable when they're done. I've been talking about it in generalities. As we mentioned, the age, the gender, the time in service, the relationship with deployments are all things that we found with this limited case control study. Some flags that we're looking at regarding contact with behavioral health diagnoses whether they're applied by primary care versus behavioral health specialists remains to be seen. And then issues about the numbers, the intensity of those visits, their spacing and what was offered during them, all of that is still a mystery but there is this concern that we either need to do better when we have

people being seen close to the time of the event or it's the ones who actually weren't being seen who turn out to be at greater risk but we just can't say that yet. So there will be more specific details and all the numbers and things to go with it in the near future.

COLONEL McPHERSON: Thank you, Dr. Cox. We appreciate your time this morning.

DR. COX: Thank you.

COLONEL McPHERSON: Our final speaker this morning is Dr. Patrick Corrigan. Dr. Corrigan is the distinguished professor of psychology at the Illinois Institute of Technology and associate dean for research. Prior to that Dr. Corrigan was professor of psychiatry and executive director of the Center for Psychiatric Rehabilitation at the University of Chicago for 14 years. He has also been the principal investigator of federally funded studies on rehabilitation and consumer-operated services. Ten years ago he became the principal investigator of the Chicago Consortium for Stigma Research, the

only NIMH-funded research center examining the stigma of mental illness. A more complete biography on Dr. Corrigan can be found at Tab 3 in your binders.

Thank you, Dr. Corrigan, and for your patience.

DR. CORRIGAN: Thank you all for inviting me to stop a minute and think about this very important issue.

I'm going to attempt to give you some idea of what my background is. I'm a person who's mostly a services researcher wondering how services in the real world play out with the kind of barriers that might pop up, and about 15 years ago we realized stigma would be one of those big barriers. To date almost all our research has not been with the military so I'm very interested in engaging you in some discussion from there. I think a lot of what we have to stay is probably still poignant and relevant.

What I want to do in our short time together is do three things. Probably I want to

focus most on change of stigma since that's what people who are interested in this area mostly care about. To do that we need to get a bit of a beginning foundation of what we know stigma is and then end up if time allows with implications for evaluating it.

I understand that on April 12 you had Linda Langford here. She's an evaluation scientist talking about messaging and suicide prevention. So what I wanted to do was put our work in perspective from what might be other ways of approaching this issue of stigma. Broadly the area of social marketing, more specifically the issue of health communication which is how do you frame messages at the public level that have the biggest impact on health-related behavior.

Our group and a lot of other research on stigma has looked at this issue as behavior change, that there are efforts in which the user or the provider or other important agents can endeavor or can pursue and have a significant impact on overcoming stigma and providing

opportunities for people to use care. Our group is funded by the National Institute of Mental Health with colleagues from these institutions. A specific area of interest for us is this idea of adherence, the idea of people using treatment and what kind of impact stigma might have on it.

I'm sure I don't have to talk to you about stigma being a problem. This is about a 20-year-old headline. Analyses of the public media will continue to show this is a problematic issue. What's important about this one headline though is that it reminds us that perhaps one of the biggest stigmas at least to people in the public is the idea that people with mental illness are dangerous and because they're dangerous they're worthy of being feared and because of that they want to be avoided. That's important because people have actually looked at this dangerousness stereotype over the last several years and seen some pretty sobering results.

The General Social Surveys, a national survey put every 2 years by the National Opinion

Research Center tries to get the blood pressure of certain issues in the public eye. In 1996, they decided to look at the issue of stigma and dangerousness in people with mental illness and they serendipitously used the same items from the 1956 survey so that it was a 40-year follow-up. What you see is endorsement of the idea of people with mental illness as dangerous has doubled which is a bit counterintuitive. You would think as we became more educated about stigma that if anything our endorsement of stereotypes would decrease. Equally sobering is in 2006 they repeated this data and they found again the same negative responses.

What I want to do is share with you a framework that we have used to understand how to change stigma. In this framework we distinguished between processes, what can an antistigma group do to challenge stigma versus vehicles? What is the medium? What is the procedure you would undertake to realize these processes and change stigma? But first we need to get some idea of what stigma is

and we pretty much have come up with this 4-by-3 matrix looking at different constructs of stigma which is largely adopted from the social psych literature and contrast it with different types of stigma.

Social psychologists will distinguish between stereotypes, prejudice and discrimination. Stereotypes about mental illness for example is that people with mental illness are weak or dangerous. In fact, I'll keep coming back to the dangerous issue about the general public and their view that people with mental illness are dangerous, unpredictable and will harm us as a result. Prejudice is agreeing with the stereotype. It's unavoidable to learn stereotypes in our culture. It's a function of growing up in the culture. People can tell me stereotypes about gays and blacks and women and the like. Those are stereotypes. Prejudice is agreeing with the stereotype, yes, all people with mental illness are dangerous and discrimination is acting on it behaviorally. Therefore, I don't want to hire

them or I don't want to serve them. So it becomes a bit of an empirical question on what are the stereotypes, prejudices and discrimination in the military.

My hunch is that this data is probably is already out there. In trying to get some sense of for example what do enlisted men or women view as fundamental stereotypes about people with mental illness, the important question here is whose perspective are you looking at so that the perspective would include enlisted personnel for sure, but NCOs and officers and even in addition other important stakeholders as you were talking earlier about the relevance of families, so clearly their perspectives on what the stereotypes of mental illness are are important as well as other faith-based and community leaders.

What we've looked at are these structures. Fundamentally for me I ask you to take those three down the side and break them into two, what are people thinking, what are people doing? Thinking is stereotypes and prejudice,

doing is discrimination. You can look at those in terms of four different types of stigma. The first type of stigma is public stigma. What does the general public do to people with mental illness in order to put them in a special class and discriminate against them? As a rehab psychologist, this is a big interest of me because I want to be able to get people back to work or living on their own and I want to know what employers will do and landlords will do to endorse the stigma of mental illness and take away opportunities from them.

Self-stigma is where the person does it themselves. Yes, all people with mental illness are incompetent. I have mental illness so I'm probably not capable of doing the kinds of things that would be expected of me. The label of avoidance is the issue that you must want to talk about today, and structural stigma, what are the societal, the economic, the political structures that are set up that either tear down stigma or put barriers up? Perhaps the biggest example in

the mental-health community is this whole issue of parity, the idea that resources for mental health should be equivalent to the resources for physical health. The question would be similar in that are there structures within the military that unintentionally perpetuate the stigma or discrimination or conversely are there efforts to try to tear them down?

The issue I want to focus on mostly today, and keep in mind from my way of looking at this issue this is only one-fourth of the piece of the pie and I keep that in mind because I think some of the questions you will have are also relevant to this idea of public stigma and self-stigma. Label avoidance is the idea of people trying to escape the stigma. In our culture one of the best ways to escape the stigma and escape the labels is don't seek out treatment because when you're seen coming out of the psychologist's office or when you're known to be taking psychoactive medications or when you're known to be seeing a minister and the like, people have

significant shame, plus whatever stereotypes are relevant in their community. We did one piece of work with the police force in the suburbs of Chicago and for them the stereotype was that if they came under mental illness they would automatically assume they were incapable of keeping their firearms and so that was a very important stereotype for them that they tried to avoid.

For us what we're interested in is how the stigma of mental illness interferes with treatment. Treatment participation is actually a little bit more complex a concept we've come to know than we first thought. I think you want to distinguish the issue between now seeking treatment and not staying in treatment. You know that epidemiologic research suggests one-third to two-thirds of people with serious mental illness will never receive treatment.

It's important to say here that I think stigma is a big part of that but by no means is it the only part. Availability of services is

important and mental-health literacy is important, but one of the big reasons why people never seek care is to avoid the stigma and the label that comes along with it.

In addition, the concern is that people who do seek care do not stay in treatment, that the normal number of treatment sessions is one, that about 85 percent or more of people with mental illness of any kind will drop out or stop using intervention as is prescribed, and we're talking specifically of not just dropping out of therapy but stop taking medications that people are on. Also, those who do stay in treatment are not fully participating in it.

Keeping that in mind then we looked at this 3 by matrix for how you actually might change stigma, that if the goal is to decrease the stereotypes about people with mental illness and goal is to get them to use treatment more often, then we have to think of what kind of approaches might we take and we distinguish between processes and vehicles. There are fundamentally three

processes people might use to change stigma, education, protest and contact. Education is reviewing the myth of mental illness and contrasting it with the facts.

For example, a very common myth is that serious mental illness is rare. We tend to call this the leprosy myth, the idea that God has struck down this certain class of people, this small, rarified group of people, for their sins and hence this idea that there really aren't a lot of people with this kind of disorder. In reality, schizophrenia is eight-tenths of 1 percent of the population which in a place like Chicago is about 64,000, but that's schizophrenia. Bipolar disorder is about three times the rate of schizophrenia, and major depression is about the order of three times bipolar disorder so that epidemiologic research at any one time suggests 1 out of 5 people meet the criteria for one of these serious mental illnesses.

So it's not a rare disorder to which people will say if it's not a rare disorder then

how come you don't see more? That's because we Americans are smart enough to know to keep it in the closet. When you're in a room with people, soldiers, students, any kind of group of people, statistically it's likely that half the people in that room in their lives will get one of these serious mental illnesses.

Education is talking about the myths of mental illness versus the facts. Protest is trying to review stigmatizing images and a shaming on us for thinking that way. For example, the daily news has get the violent crazies off the streets and we actually have a slow of slides like this ending up with the message that it's wrong for us to have these viewpoints, that it's a stigmatized group, that we should stop pursuing this kind of approach. Generally research suggests at least for changing attitudes that it doesn't work very well, that if anything it tends to have this rebound effect, this don't tell me what to think kind of idea.

Social psychologists like to talk about

the white bear, so that in the next 5 minutes do not allow a white bear in your head, and my hunch is that people are really working at that now with the Klondike bear bouncing around in their heads. It's hard to suppress an idea. It's hard to tell a group not to act on that idea. So if the goal is to go to a group, to go to a group of NCOs for example, and change their attitudes about mental illness, this sort of protest or sort of punishing sort of approach will actually probably make it worse.

Contact. We've worked with a gentleman named Bob Lundine who is a person with schizoaffective disorder to tell this story. In this kind of contact research, Bob comes in and tells this story with these key points. One of the points is the idea that he has a serious mental illness called schizoaffective disorder and what's part of this? That the importance of talking about childhood is not unusual, that the public tends to view people with mental illness as somehow boring, strange or scarred, that in fact

he had a sort of "normal" high school and that college years is when this illness tended to come back on him. That this is a traumatic event, that this isn't test anxiety or the normal kind of depression, that it's disabling, and that despite all that he was able to achieve several accomplishments, the kind of status that's appropriate for his cohort, so people are able to live independently, work successful jobs and build adult and mature relationships with other people.

We've done some research, this is more social psychological research of randomized design in an experimental setting on different groups of people, and I wanted to show you two of the studies because I think it illustrates some interesting issues about examining this. We took a group of 152 people and randomized them to education, protest and contact for control. The education was the myth of mental illness versus the facts. Protest was shame on you. Stop thinking that way. Contact was Bob Lundine telling his story. And control is the control

group. We collected data on what's grossly at this point called the mental illness stigma scale. We collected that data before into the conditions and significantly after. What we found is I want to show you two graphs.

This is an important graph because this is looking at the issue of stability, the issue of does the psychosis go away. It's very popular in the civilian literature to say mental illness is a brain disorder thinking that when the public views mental illness as a brain disorder they'll let them off the hook, they won't be so demanding of them, they'll give them some sympathy as it were. For the most part, in mental illness as a brain disorder there's a great effect on whether or not you're to blame for your mental illness and also it has a huge effect on whether people will get better. So when you put around this idea of mental illness as a brain disorder it tends to increase the solidity in which the public looks at this sort of thing. In this case we were looking at stability, whether or not the view that people

with mental illness will change, will get any better.

This is interesting both for methodological reasons and outcomes. Look at the control condition first. Reductions is good. When you look at the control condition you see a big reduction in its own right. The reason you see a big reduction in its own right is because of social desirability, that living in Western cultures, living in our culture, we realize you don't want to come out looking like a bigot and if people are asking you questions twice about this, people tend to game the exercise and realize you want me to see whether I've gotten any better so that just doing nothing leads to big reductions. Statistically to make any sense of this you have to look at the interaction effect, the differences between education and control in pre and post and differences between contact and control in pre and post. In fact, with education and contact there are significant interactions so that they create a significant difference compared to the control

group.

Another interesting thing is that the protest group actually didn't change much, so that despite social desirability, it seemed to suppress their sense of believing that any kind of positive benefits -- one more graph from that study, again this is looking at the controllability of depression, the idea of blaming people with mental illness. The way the score works is the higher the score, the less likely you are to blame people. What you find here is mostly what you find in a lot of research, education tends to lead to a little improvement but not much, contact led to a huge improvement. So we were really interested in looking at this issue of contact versus education. I think education is a very popular way in which Americans like to respond to social problems, and don't get me wrong. I think there is some benefit in that. The idea that we quickly put together a manual and spell out the facts about certain illnesses or conditions and juxtapose that against the myths and it turns out

to be some kind of big impact.

What we were interested in is looking at the effects of education versus contact and did it vary depending on what you were talking about. We randomly assigned people to four conditions, two conditions about education, two conditions about contact, so we threw protest out of the picture. What they talked about in the conditions we specified so that the education condition were the facts versus the myths about whether people are to blame for their illnesses. Dangerousness is the facts and the myths versus whether or not they're dangerous, there should be some ways to avoid being frightened of. Contact was Bob telling his story about whether he's responsible for it and Bob telling his story about dangerousness. And to remind you, Bob was my colleague who has schizoaffective disorder. What's important about this is several. Amongst other things, one of the things that's important about it is that it actually had follow-up data so we could see what kinds of effects were maintained over time. So we

were interested in seeing how issues like dangerousness and avoidance improved or not so over time.

I'm going to show you three graphs. They're all set up pretty much the same way. Control is the control condition we talked about. Again you see some small improvement there, so that's the social desirability effect. You have two education conditions, one on dangerousness and one on responsibility. And you have two contact conditions, one on dangerousness and one on responsibility. What you find is pretty much what we found over studies over the last several years. Education leads to small effects, contact leads to big effects. Dangerousness which is fundamentally an attitude. We also came up with a proxy of avoidance and whether or not you want to stay away from people with mental illness. Again you see a tiny effect in terms of education and a huge effect in terms of contact. Come back later, come back 2 weeks later, whatever effects there were to education have gone away and contacts led to big

change. Which suggests to us one of the big ways in which you want to challenge the stigma of mental illness is terms of this idea of facilitating interactions with people with mental illness. So I came in at the very end of the discussion prior to the one that we just heard and they talked about having veteran peers which would be quite consistent with the kind of ways we would argue you want to challenge and take on the stigma of mental illness.

We've been talking about protest, education and contact and the vehicles in which you do it largely might be looked at in terms of media based and in vivo where oversimplifying it entirely is media based, maybe some sort of public service announcement approach or in vivo might be some local targeted way of dealing with the stigma of mental illness.

Let's talk about public service announcements. The Substance Abuse and Mental Health Services Administration has produced several PSAs over the last several years and

actually they're ready to go field yet another. This is actually one put together by Glenn Close whose sister Jesse Close has bipolar disorder and in this 30-second public service announcement which had some wide play around the media, what you are people pared up.

So there was a man with a yellow shirt that said schizophrenia and next to him was a woman that said mother. In this case you had a man with PTSD, next to him was a person that said battle buddy. I went and did a presentation at the Uniformed Services University and actually met the lady on the right who was the general and the gentleman on the left is the person with PTSD, then finally Glenn Close and Jesse Close. I used this because some people may have seen this in the media and one of the benefits of Glenn Close doing this kind of thing is the immediate cache. She was on "Oprah" and other talk shows and it had a pretty big impact.

What does the research show about the public service announcements? One thing you see,

this is a sort of collection of research in public serve announcements. One thing you see is in January 2008 the Substance Abuse and Mental Health Services Administration put out a public serve announcement and this was a stratified random population that they recruited and what they found pretty interestingly is 31 percent of the people who they interviewed actually remembered seeing it which to me is pretty impressive. Coming back a year later it's still around 28 percent so there's still a pretty significant impact in terms of whether people remember seeing the public serve announcement and if PSAs are going to have any impact they have to meet that criteria first, that people have to remember at least seeing it.

What a lot of public serve announcements have done is they've developed websites. Again this is the SAMHSA website, or much more relevant to work you all are doing is realwarriors.net which is put out by the Center of Excellence, an outreach program, and on this website which is typical of most websites there's basic useful

information.

In addition to that there are direct links to the Suicide Prevention Lifeline so there is usually a hot button that people can go to right away if they're currently in need. They also have other websites that are relevant, for example, afterdeployment.org which is a website dealing with that group of people. They tend to have live chat rooms.

What's exciting about websites both in terms of having a real meaningful impact on people and studying that impact is going to websites potentially seems to be a good way of benchmarking whether or not any kind of public serve announcement has an impact on people. In fact, one study they showed is they looked over the course of a 3-month blanketing of a public serve announcement and what kind of impact it had in terms of going to websites, and it went from 2,500 people going to the website to 8,000 people going to the website, a ratio of 2.8 that is pretty good. Here's a sobering thing when you think

about this because that public serve announcement was in a community of eight states with millions of people. One of the states was California, about 150 million people, and in that state of 150 million people, the number of people who went to the website went from 2,000 to 5,000. If you can't see it down at the lower bottom, that would be the effect size of it.

What's equally sobering about it is of those people who went to the website, about 88 percent left after 1 minute was up or less, so that people are going to the website and they're not sticking at the website. Some people will say to me that really is no different than other public serve announcement campaigns in terms of what kind of hit rate they got which is true but still sobering. What kind of effect can these websites have if people aren't going to them and sticking at them?

In addition, what I would say is the committee needs to consider promoting some sort of interaction between what is traditional social

marketing PSA ways of looking at these kinds of things and much more in vivo local ways. One in vivo program which is a wonderful example is the National Alliance of Mental Illness in Our Own Voice and it's a program developed by people with mental illness who go out and tell their story. In another study we randomized people with three conditions. Education was considered our baseline. This is the myths versus the facts.

The original program of In Our Own Voice was 90 minutes long and their intention was to, for example, go to Rotary and tell their stories or go to the police roll call in the morning and tell their stories, and I think you guys quickly realize that 90 minutes is an unbelievable amount of time to ask from anybody. So we reduced it down to 30 minutes with a lot of feedback from them and found out as a result that education actually led to fewer positive changes than the 30 minute and the 90 minute, and actually in these results you also find that the 30-minute data is about the same as the 90-minute data. So this

30-minute program worked about as effectively as the 90-minute program and both of those led to pretty significant differences.

Another part of good stigma change whether it be at the level of PSAs or more at the level of in vivo is the idea of targeted change and local change. To me I think we're pushing for trying to move away from this idea of educating and affecting the entire the population. I think partly that's the goal of public serve announcements. Again Glenn Close can get out there and get this message out there really fast and has huge cache in terms of the population remembering that kind of thing. I'll go around for example and say how many people remember the Glenn Close thing? How many people remember these other ones that they did? About 1 out of 10 remember the SAMHSA ones, but about 1 out of 5 to 1 out of 4 remember the Glenn Close one. So it had some pretty big impact. The problem is we're trying to affect the overall population rather than trying to target it.

For me targeting has been looking at these groups like landlords and health care providers and there is some very sobering research that suggests for example that if a person with mental illness goes to a physician and during the interview the physician finds the person has schizophrenia, they're significantly less likely to be referred to specialists. Particularly the vignette that people use in this situation was referral to a cardiologist. You see difficulties with legislators and the like. So of course one of the big targeted groups for what we do is we're trying to move out of these big social areas which have importance but not the goal here to talk about the distressed person. The distressed person we're most interested in, the soldier with PTSD, hold the phone, also talk about the sailor, the Marine or the airman and the one idea we'll place for you is that chances are the stigma for soldiers varies from sailors and Marines and the like.

Local stigma change, we'll start with

the idea of trying to impact the soldier or sailor and look for local variables that might be relevant. What I would argue is that probably local relevant variables would be branch of the service or whether they're enlisted personnel, noncommissioned officers or officers. What kind of disorder is it that you're talking about?

One of the most interesting things is ethnicity or gender. We actually were funded to do a study about 4 years ago looking at the stigma of mental illness in African Americans on the west side of Chicago. What we found most interesting is a lot of people in that community said that going to services for mental health is letting down your church, that the purpose of your church is to handle these kinds of personal needs and seeking outside the church is problematic. So likely this whole idea of stigma change is going to vary by ethnicity or gender.

An equally interesting and perhaps provocative issue is doing it locally, not just locally by service branch, but locally perhaps by

base or by unit. Of course, we can't make these decisions lightly because we realize that any kind of discussion about people with mental illness has huge risk and so doing these kinds of local programs you have to have some sense of what the risk is and how the person can be protected.

The benefits of a targeted approach to change is its impact on the message, the medium and the outcome. The message is this is the type of stereotype you're dealing with and the fact that that type of stereotype is not true and more importantly shouldn't lead to some sort of discrimination. The medium is not just public serve announcements, not just in vivo, but the two of them together. Which is interesting because it would require partly to think in a different way in that issues of social tend to be in one camp and people with this kind of in vivo focus tend to be in another camp -- somehow to put it together in some kind of important overall campaign and program.

Then the outcome. What do you want to

fix? What you want you fix in some ways isn't that hard a question at least when you look at it in terms of valuation. As a rehab person what I want to fix is I want more employers to interview people with mental illness and I want more employers to hire people with mental illness. In the issue we're talking about here, I want more enlisted men and women not to avoid services, and of course we realize not to do something is not a good target for understanding for evaluation. More importantly, I want to know how we can get more enlisted men and women to seek out services, and once they go into services to stay in services and participate fully.

The last point I had here was this whole idea of how to evaluate the interventions. What does the science say? The good news is there's a lot of research out there with a lot of points about what the science says and I didn't feel like I'd have enough time to go into it other than the ones I showed you. We've made some effort of trying to summarize this into a cogent way of

approaching the issues of stigma change, and about 4 years ago we prepared this manual "Beat the Stigma and Discrimination for Advocates" on how to change the stigma of mental illness which I understand is in your electronic archive for those of you who want to look more at the issue.

Even more importantly, based on NIMH research we're come up with a pretty big toolkit of about seven measures that have been pretty well supported in our research about how to look at this issue of stigma and mental illness. As we do more and more work we're more and more interested in small specific groups. As I say, we're doing research right now with police officers and what the stereotypes are relevant to polices officers are different than this "group" we have in our toolkit. So my hunch is the same thing would apply in terms of trying to make sense of what the stigma and stereotypes are for enlisted men and women and this may be a good model for that kind of approach or we may need additional research to get some sense of what the relevant stereotypes

are.

Again in your electronic archives we've provided a copy of the bibliography of work we've done in the area, the toolkit and the four lessons, and my email if you'd like to talk more. Questions or comments?

COLONEL McPHERSON: Thank you, Dr. Corrigan. Are there any questions? Dr. Bradley?

LIEUTENANT COLONEL BRADLEY: John Bradley here. I'd like to follow-up on one aspect of stigma. Has your group looked at the question of stigma as a result of hopelessness about treatment, that treatment doesn't work; if it's a brain disease, why should I go anyway?

DR. CORRIGAN: That's a good predictor of whether seek out treatment. Related to it is the whole idea of self-determination, do you have the belief that participating in treatment will first be relevant to your goals and second will be change your goals in a direction that's positive and important?

Some people talk about this in terms of

mental- health literacy. Again the idea of mental-health literacy is learning the facts about illnesses and treatment and mental-health literacy seems to be less implicated here than it does again of having models of people who sought treatment who are people worthy of being a model for me and they've done well by seeking treatment.

My brief way of approaching would say the things that the military is already doing to show the average GI Joe and Jane approaching these kinds of issues in a competent way that protects their role in the military the more we are to tear down the stigma.

MAJOR GENERAL VOLPE: Dr. Berman?

DR. BERMAN: First of all, thank you very much. It was a very understandable and terrific presentation. Can you comment a little bit about sustainability of both impact and change? That is, what kind of duration and what kind of impact is necessary to accomplish true change of attitude or belief over what period of time?

DR. CORRIGAN: What we would like to do is almost have a psychiatrist's or psychologist's viewpoint about this, I'm going to go and I'm going to give you a pill and you're going to get better. What we know about psychology and psychiatry is you have to maintain the intervention over time, so it's the same thing like stigma change. Our goal is to go out and hit you with a PSA and think we're going to solve the problem that it's going to go away. I think one of the challenges is how the military provides and maintains antistigma programs that are relevant to the men and women they're trying to address. One time can end up with significant changes but won't maintain over time.

COLONEL McPHERSON: Are there any further questions?

DR. HOLLOWAY: Thank you so much for your presentation. I'm wondering based on your knowledge of the literature on stigma what are some of the recommendations that you have for the task force pertaining to suicide prevention within

DOD?

DR. CORRIGAN: I think you want to like any kind of work avoid reinventing the wheel, so I think you need to find out what's out there. Again the Center of Excellence has produced this website of real warriors. I was at a meeting with USHUS and there are quite a few people in the military trying to address these kinds of things, and Bob Rosano is doing a lot of good work in that regard. My hunch is our natural inclination is to pursue public serve announcements and cross-population sorts of interventions. Again I'm not saying they're not useful. Glenn Close hit 100 million people the first week she went on TV and that's a big impact. I think you're looking for much more slowly locally maintaining messages about mental illness and mental-health services sorts of stuff over time.

We told you we did this work in the black community that showed the black community at least in the study we worked at was concerned about mental health not fitting in their view of

what the ministry is. So we followed this up with a public health program sort of bastardizing the New Testament of give to Cesar what's Cesar's and give to God what's God's, so give to the minister what spiritual issues and give to the psychologist what's mental-health issues and try to maintain that over time.

COLONEL McPHERSON: Are there any other questions? Dr. Litts?

DR. LITTS: Thank you. I think this is a nice complement to what Linda Langford presented at our last meeting. And I also think it's very important for us as we're thinking about stigma to unpack it to this stereotype, prejudice, discrimination. One of the problems that we've seen in our site visits is that there is a lot of discrimination out there. People who are identified as needing mental-health care get treated very differently and some of that is by reg because of the military's mission, but a lot of it is just because of elective behavior in their chain of leadership. I think that we've got

something here much more difficult to address than mere perceptions so I think that your advice about needing a lot more than a public relations or public education campaign is very helpful.

DR. CORRIGAN: Let me again echo that you need to think about who are the targets of this. Clearly the enlisted men and women are targets, but no doubt people up the chain of command who are relevant to their day in and day out messages are very important, so noncommissioned officers I think would be really essential. Also the older I get, the worse my memory gets, and hopefully you can help me recall this. Last year or so an active-duty General in the military came out with PTSD and stayed in the military, by the way. That's gutsy. That's a huge message. That's not enough for the sailor on board the ship because then he's going to need his local noncommissioned officer who he will be giving that message to, and any of the stigma needs to translate into some sort of specific behavior, not just I want you to start thinking

bad things about people with mental illness, it's I want you to think that if you have a mental illness you can fix it or you can help it or something and here's the treatment to do it.

COLONEL McPHERSON: Thank you very much, Dr. Corrigan. We appreciate you coming out for us. Thank you.

DR. CORRIGAN: Thank you.

COLONEL McPHERSON: At this point we would be able to open the meeting up to public comment, however, we have run over our time and we have no one signed up to make a public comment. So I would like to remind people in the audience or anyone else that everyone does have the opportunity to submit written statements to the task force. They may be submitted today at the registration desk or by email at dhb@ha.osd.mil, or may be mailed to the Defense Health Board office, and again those addresses are available both in the Federal Register and at the registration desk outside this room.

MAJOR GENERAL VOLPE: At this time this

concludes the morning session. We're going to go ahead and break for lunch.

(Whereupon, at 12:17 p.m., the PROCEEDINGS were adjourned.)

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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